Federal Democratic Republic of Ethiopia
Ministry of Health

Health Sector Development Program IV
2010/11 – 2014/15

FINAL DRAFT

October 2010

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARM	Annual Review Meeting
ART	Anti Retroviral Therapy
ARV	Anti-retroviral Drug
BEOC	Basic and Emergency Obstetric Care
CJSC	Central Joint Steering Committee
CSA	Central Statistical Authority
CSRP	Civil Service Reform Program
DACA	Drug Administration and Control Authority
DOTS	Directly Observed Treatment Short Course
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey 2000
EHNRI	Ethiopian Health and Nutrition Research Institute
ENA	Essential Nutrition Actions
EFY	Ethiopian Fiscal Year
EOC	Emergency Obstetric Care
EPHA	Ethiopian Public Health Association
EPI	Expanded Program of Immunization
FMOH	Federal Ministry of Health
FP	Family Planning
FY	Financial or Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization
GC	Gregorian Calendar
GDP	Gross Domestic Product
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
GMP	Good Manufacturing Practices
GNP	Gross National Product
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HCF	Health Care Financing
HEP	Health Extension Package
HEW	Health Extension Workers
HF	Health Facility
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
HPs	Health Posts
HSDP	Health Sector Development Programme
ICB	International Competitive Bidding
IEC/BCC	Information, Education and Communication/Behavioral Change Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Nets
JCCC	Joint Core Coordinating Committee
JCM	Joint Consultative Meeting (FMOH and HPN group)
JRM	Joint Review Mission
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOFED	Ministry of Finance and Economic Development
MPS	Making Pregnancy Safer
MTR	Mid Term Review
NAC	National Advisory Committee
NCB	National Competitive Bidding
NCDs	None-communicable diseases
NTDs	Neglected tropical diseases
NDL	National Drug List
NHA	National Health Accounts
PHCU	Primary Health Care Unit
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPPH	Public-Private Partnership for Health
PRSP	Poverty Reduction Strategy Paper

RH	Reproductive Health
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
SAFE	Surgery, Antibiotic, Face washing and Environmental Improvement
SNNPR	Southern Nations Nationalities and Peoples Region
STIs	Sexually Transmitted Infections
SSA	Sub Saharan Africa
TB	Tuberculosis
TBAs	Traditional Birth Attendants
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZHD	Zonal Health Department

Chapter 1 Country Profile

This chapter gives an over view of the profile of Ethiopia in terms of geography and climate, demographic situation, education, administrative structure, socioeconomic situation , health status and health system organization.

2.1. Geography and Climate

Ethiopia is Africa's oldest independent country. It is the tenth largest country in Africa, covering 1,104,300 square kilometers (with 1 million sq km land area and 104,300 sq km water) and is the major constituent of the landmass known as the Horn of Africa. It is bordered on the north and northeast by Eritrea, on the east by Djibouti and Somalia, on the south by Kenya, and on the west and southwest by Sudan. Its geographical coordinates are between 8 00 N and 38 00 E.

Ethiopia is a country with great geographical diversity and its topography shows a variety of contrasts ranging from high peaks of 4,550m above sea level to a low depression of 110m below sea level. More than half of the country lies above 1,500 meters. The predominant climate type is tropical monsoon, with temperate climate on the plateau and hot in the lowlands. There are topographic-induced climatic variations broadly categorized into three: the "Kolla", or hot lowlands, below approximately 1,500 meters, the "Wayna Degas" at 1,500-2,400 meters and the "Dega" or cool temperate highlands above 2,400 meters.

2.2. Demographic Situation

Projections from the 2007 population and housing census estimate the total population for the year 2010 to be 79.8 million.. Ethiopia is the home of a mosaic nations, nationalities and peoples varying in population size from more than 18 million to less than 1005 spread across the country and with more than 80 different spoken languages. According to 2007 census, the country is among the least urbanized country in the world with 83.6% living in rural areas whilst 16.4% of the total population living in urban areas. The largest city in the country is Addis Ababa, the capital, with 2.7 million people accounting for nearly 4% of the total population. The average size of a household is 4.7.

The pyramidal age structure of the population has remained predominately young with 44% under the age of 15 years, and over half (52%) of the population in the age group of 15 and 65 years. The population in the age group of over 65 years accounts for only 3% of the total. While the sex ratio between male and female is almost equal, women in the reproductive age group constitute 24% of the population. The average fertility trend in recent years has shown some significant decline from the 1990 level of 6.4 births per women to 5.4 births (DHS 2005), an average of one birth drop per women in 15 years[i]. The estimate also showed that there are variations in fertility trend among rural and urban areas with rural women having an average of three more births per woman compared to their counterparts in urban areas. Whilst the population is still growing faster at an annual rate of 2.6 %, the lowest population growth is recorded for Amhara region, which is 1.7%, significantly lower than population replacement.

2.3. Government and Administration

Ethiopia is a Federal Democratic Republic under the 1994 constitution. It has three branches of governance and administration. The executive branch includes the Prime Minister, Council of

Ministers and Council of State. The legislative branch have a bicameral Parliament consisting of the House of Federation or upper chamber and the House of People's Representatives or lower chamber, the latter being elected by popular vote from single-member districts to serve five-year terms. The judicial branch comprises federal and regional courts.

The Federal Democratic Republic of Ethiopia is composed of nine Regional States: Tigray, Afar, Amhara, Oromia, Somali, Southern Nation Nationalities and Peoples Region (SNNPR), Benishangul-Gumuz, Gambella, and Harari; and two City Administrations council of Dire Dawa and Addis Ababa.. The regional states and city administrations are subdivided into 817 administrative Woredas (districts). A Woreda/District is the basic decentralized administrative unit and has an administrative council composed of elected members. The 817 Woredas are further divided into about 16,253 Kebeles, the smallest administrative unit in the governance. There are also two zones and seven Woredas designated as "special". These are medium sized towns or traditional sites of various nations.

2.4. Socio-economic Situation

The Government of Ethiopia follows a market–based and agricultural led industrialization economic policy for the development and management of the economy. There have been a number of policy initiatives and measures taken in these directions which included privatization of state enterprises and rationalization of government regulation which the process is still ongoing. Ethiopia's economy depends heavily on the agricultural sector. Agriculture accounts for 83.4% of the labour force, about 43.2% of the Gross Domestic Product (GDP) and 80% of exports[ii]. The regular droughts combined with poor cultivation practices, make Ethiopia's economy very vulnerable to climatic changes.

Despite these obvious challenges, Ethiopia has shown an impressive economic growth over the last seven years, although the per capita of 235 USD remain below the Sub Saharan average. But, Poverty Head Count Index has declined from the 1996 level of 45.5% to 32.7% in 2007/08.[iii] The reduction in poverty has been more pronounced in rural areas than in urban areas. The overall economic dependency ratio for the country is estimated at 93 dependents per 100 persons in the working age group of 15-64 years.

During the SDPRP I period (2002/03 - 2004/05), real GDP grew on average by about 5 percent per annum. However, during the first three years of PASDEP period the country registered an average of double digit economic growth of 11.8% per annum with steady and strong positive performance in real GDP[iv]. This steady growth marks a significant progress, not only compared to the 7% annual growth target that would be required to meet the MDGs, but also to realize Ethiopia’s objective to become a middle-income country in the next two decades.

Another important feature of the economic reform in Ethiopia is equal opportunity for women in the participation of the economic development of the country which is enshrined in the constitution. The Ethiopian Constitution recognizes the principle of equality of access to economic opportunities, employment and property ownership for women. Following this, the government has formulated a national gender policy, which recognizes equality between the sexes and sets up mechanisms for the improvement of women’s conditions, such as the establishment of the Ministry of Women’s Affairs. The main strategies employed to implement the national policy include gender mainstreaming in sector and development programs, advocacy and capacity-building initiatives.

2.5. Educational Status

The intimate linkage between health and education has been firmly established in a number of studies which could potentially reinforce each other towards a rapid socio-economic development of a country, especially in developing economies. Education is one of the most critical variables in epidemiological and health service research in Ethiopia and illiteracy is usually associated with high risk and low health seeking behavior. In addition to a wide range of disease and child mortality associated with illiteracy or under education, unfortunately HIV/AIDS infection is disproportionately high in out of school youth. The general level of education in a country becomes a marker significantly influencing the spread of disease, shaping the health seeking behavior of individuals and communities including the utilization of modern health care service.

Despite major progresses in Education, the literacy status of the population of Ethiopia is still low. The total adult literacy rate (whose age is above 15 who can read and write) is 36% (62% for male and 39% for female). According to MOE 2010 Progress Report, there has been an increase in the gross enrollment ratio from 2.2% in 2004/05 to 4.2% in 2008/09. The gross enrollment ratio in primary school has risen from 32% in 1990/91 to over 91% in 2006/07, giving a male to female proportion of 55.9% and 44.1%, respectively. This indicates that the gap between school boys and girls has continued to decline although still exist regional disparities in the primary GER. During the period 2004/05 to 2008/09, the overall enrollments as well as the intake capacity of the higher education institutions have significantly increased from 138,199 to 304,371, resulting in a higher education GER increase from 3.6% in 2004/05 to 4.6% in 2008/09. This figure puts Ethiopia achieving close to the African average in GER of 6% in 2007/08.

2.6. Health Status

The major health problems of the country remain largely preventable communicable diseases and nutritional disorders. Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Figures on vital health indicators from DHS 2005 show a life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010[v] and more than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions. These are very high levels, though there has been a gradual decline in these rates during the past 15years. In terms of women health, MMR has declined to 590/100,000 though it still remains to be among the highest[vi]. The major causes of maternal death are obstructed/prolonged labor (13%), ruptured uterus (12%), severe pre-eclampsia/ eclampsia (11%) and malaria (9%)[vii]. Moreover, 6% of all maternal deaths were attributable to complications from abortion. Shortage of skilled midwives, weak referral system at health centre levels, lack of inadequate availability of BEmONC and CEmONC equipment, and under financing of the service were identified as major supply side constraints that hindered progress. On the demand side, cultural norms and societal emotional support bestowed to mothers, distance to functioning health centers and financial barrier were found to be the major causes.

Following changes of Government in 1991, the Government produced the health policy which was the first of its kind in the country and was among a number of political and socio-economic transformation measures that were put in place. The translation of the health policy was followed

by the formulation of four consecutive phases of comprehensive Health Sector Development Plans (HSDPs), the first phase of which was implemented starting in 1996/97. Both of the policy formulation as well as the development of the first HSDP have been the result of critical reviews and scrutiny of the nature, magnitude and root causes of the prevailing health problems of the country and the broader awareness of the newly emerging health problems in the country.

The core elements of the health policy are democratization and decentralization of the health care system, development of the preventive, promotive and curative components of health care, assurance of accessibility of health care for all segments of the population and the promotion of private sector and NGOs participation in the health sector.

Since the development of HSDP I which also paved the way for the subsequent HSDP II and HSDP III, the Federal Ministry of Health has formulated and implemented a number of policies and strategies that afforded an effective framework for improving health in the country including the recent addition of maternal and neonatal health. This include implementations of far reaching and focused strategies such as Making Pregnancy Safer (2000), Reproductive Health Strategy (2006), Adolescent and Youth Reproductive Health Strategy (2006) and the Revised Abortion Law (2005). Others include strategies on free service for key maternal and child health services (Health Care Financing Strategy), the training and deployment of new health workforce called all female HEWs for the institutionalization of the community health care services including clean and safe delivery at HP level, and deployment of HOs with MSc training in skills of Integrated Emergency Obstetric and Surgery (IEOS). In addition, the establishment of the MDG Performance Package Fund and the priority given to maternal health therein is expected to mobilize the much required additional funding opportunities.

2.7. Health System Organization

The recently implemented BPR of the health sector has introduced a three-tier health care delivery system which is characterized by a first level of a Woreda/District health system comprising a primary hospital (with population coverage of 60,000-100,000 people), health centers (1/15,000-25,000 population) and their satellite Health Posts (1/3,000-5,000 population) that are connected to each other by a referral system. A Primary Hospital, Health center and health posts form a Primary health care unit (PHCU) with each health center having five satellite health posts. The second level in the tier is a General Hospital with population coverage of 1-1.5 million people; and the third a Specialized Hospital that covers population of 3.5-5 million. The Ethiopian Health care System is augmented by the rapid expansion of the private for profit and NGOs sector playing significant role in boosting the health service coverage and utilization thus enhancing the public/private/NGOs partnership in the delivery of health care services in the country.Offices at different levels of the health sector from the Federal Ministry of Health to Regional Health Bureaus and Woreda Health Offices share decision making processes, decision powers, duties and responsibilities. The FMOH and the RHBs focus more on policy matters and technical support while Woreda Health Offices have basic roles of managing and coordinating the operation of a district health system under their jurisdiction.

Regions and districts have Regional Health Bureaus (RHB) and district health offices, respectively for the management of public health services at their levels. The devolution of power to regional governments has resulted in the shifting of decision making for public service deliveries from the center to largely under the authority of the regions and down to the district level.

Chapter 2 : Overview of HSDP I, II and III

The three consecutive HSDPs that have been implemented since 1997/98 are reviewed here with respect to achievements, implementation challenges and lesson learned and doable recommendations for further health sector planning.

Records from the implementation of HSDP I and II showed encouraging improvements both in the health service coverage as well as in the utilization of services at all levels of the health care system of Ethiopia. In terms of physical health facilities, the improvements have been the construction of additional 3,135 New Health Posts reaching 2899 in 2003/04[viii]. This was from an insubstantial of 76 HPs in 1996/97. The number of Health Centers has also increased from the 1996/07 level of 243 to 519 in 2003/04. Similarly the number of Hospitals has increased from 87 in 1996/97 to 126 in 2003/04. There have been also significant increases in the availability of health workers of all professional categories among which the increase in the number of Nurses and Health officers have been most remarkable. The end phase in the implementation of HSDP II saw the development of new strategic initiative that brought in the inception, successful piloting, and the launching of HEP at the national level with the aim of universal PHC coverage and institutionalization of the community health services at health post level in the midst of villages. The program has required the training and deployment of all female HEWs, and by the conclusion of HSDP II, there have been 2,800 trained and deployed HEWs with 7,138 already enrolled for training in 2004/5[ix].

In terms of progresses in the implementation of priority health programs including prevention and control of infectious communicable diseases such as HIV/AIDS, Malaria and TB, the recorded achievement showed that there have been notable sign of improvements during these periods, especially family planning services such as contraceptive coverage which has shown a remarkable leap from the 1996/97 level of 4% to 25% in 2004/05[x].

The following sections provide detailed account of performance of HSDP III in priority programs and health system issues.

2.1. Health service Delivery and quality of care

2.1.1 Family Health Service

2.1.1.1 Maternal Newborn, Child, and Adolescent Health

The major targets for achievement in family health services under HSDP III were: to increase family planning service coverage (CPR) from 25% to 60%, institutional deliveries attended by skilled health workers from 12% to 32%, provision of BEmONC in 100% of HCs, CEmONC in 87% of the hospitals and 20% of the HCs. Other targets were increasing DPT3/Penta3 coverage from 70% to 85%, proportion of fully immunized children from 45% to 80%, expansion of IMNCI implementation from 36% to 90% of Health Facilities, and CIMNCI implementation from 12% to 80% of the districts in the country.

In order to achieve these targets, there have been substantial investments in the procurement of equipment for clean delivery and B/CEmONC services. Accelerated training of health officers

has been initiated and around 5,000 were enrolled, of which about 70% were graduated and deployed. Masters level program in Emergency Surgery and Obstetrics for health officers has been introduced and the first batch has already graduated and deployed.. The inadequacy of the pre-service training of HEWs in MCH has been recognized, and a one month in-service training has been designed and implemented in all regions. Key pilot initiatives such as Making Pregnancy Safer have been evaluated.

Subsequently, Antenatal care coverage has reached 68%, Post natal care 34% and family planning acceptors coverage as measured by the contraceptive acceptance rate has reached 56.2 % in 2008/09. [xi]. Clean and safe delivery by HEW has increased to 10.8%. There has been an increase in the percentage of deliveries assisted by skilled health personnel reaching 18.4 % from the baseline of 12% with a wide variation among regions. Regional disaggregation has also shown a performance ranging from as low as 5.6% in Benishangul Gumuz region to 62.5% in Addis Ababa, while five regions (Tigray, SNNPR, Harari, Addis Ababa, and Dire Dawa) performed above the national average[xii].

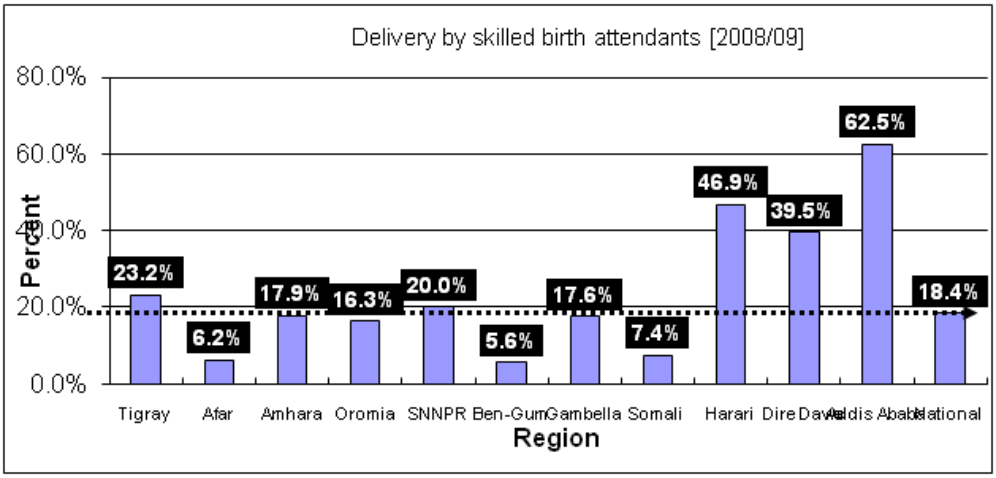


Fig 2.1, Delivery by Skilled Birth Attendants in regions, 2008/09

Furthermore; Out of the total of 111 hospitals on which EmONC assessment was conducted in 2007, 51% provided comprehensive EmONC, 14% of the hospitals provided basic emergency obstetric services while 34% of the hospitals partially function on EmONC[xiii]. Similarly, a total of 684 health centers provided obstetric and neonatal services of which only one health center provided comprehensive EmONC, nine Basic and 674 provided partial EmONC services which are far behind the targets set in HSDP III.

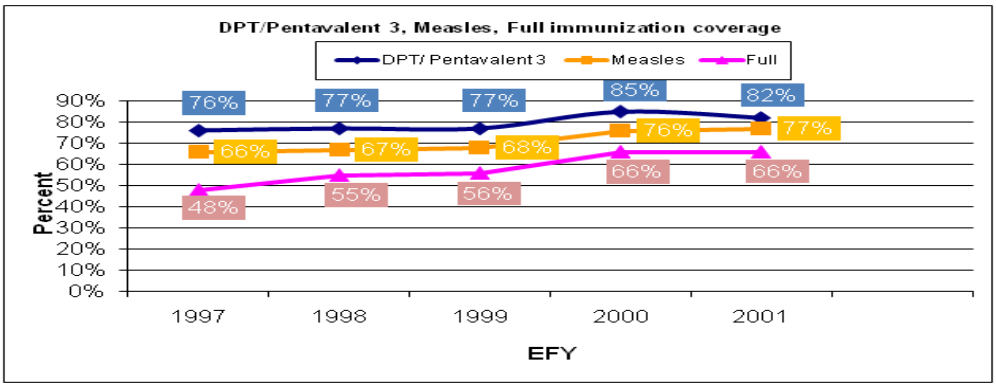


Figure 2.2 Trend in Immunization Coverage, EFY 1997-2001

One year before the termination of HSDP III, Pentavalent immunization coverage has reached 82% and measles immunization coverage 76.6%, while the percentage of fully immunized children has reached 65.5%[xiv]. In this regard, HSDP III target has been already achieved for measles immunization coverage and nearly so for the percentage of fully immunized children. Similarly, five regions (Addis Ababa, Harari, Amhara, Tigray, and SNNP) have persistently showed better achievements than the national average for the last three consecutive years while, Gambella, Afar and Somali regions seem to be far less than the average performing half below the targets.

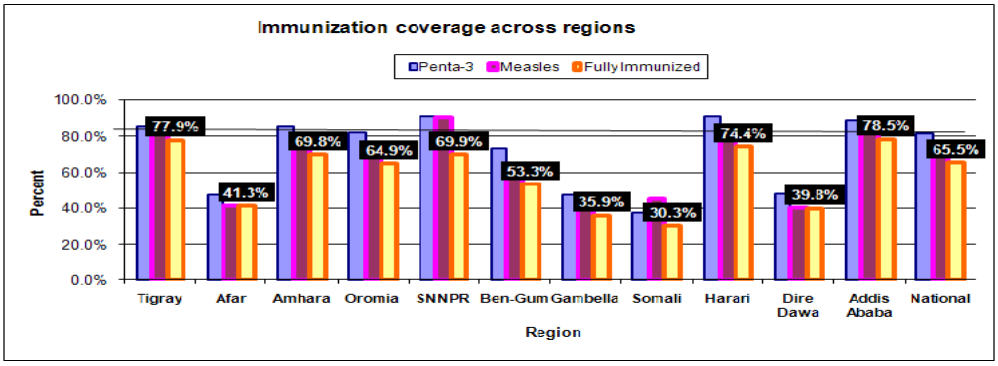


Fig 2.3, Immunization coverage across regions, 2008/09

The EmONC Assessment Report illustrates that almost half of the facilities did not provide newborn resuscitation and only 80% provided parenteral antibiotics. Lack of equipments such as "Ambu-bags" and masks, and shortage of skilled workers have been identified as the major constraint for such low performance. According to FMOH 2008/09 administrative report, only 930 health centers (68.2) and 81 hospitals (72.9%) were providing IMNCI while 215 Woredas in ten regions provided Community IMNCI interventions, all short of achieving the planned targets.. Further more; encouraging progress was made in terms of developing strategies, guidelines, and standards for Adolescent and youth reproductive health. Minimum service

delivery packages for youth friendly reproductive health service was prepared and health care providers were trained on areas of youth friendly services.

2.1.2 Prevention and Control of Diseases

The progress in prevention and control of malaria, HIV/AIDS, Tuberculosis and leprosy, Blindness and Onchocerciasis is described below.

2.1.2.1 Malaria and Other Vector born Diseases Prevention and Control

Malaria prevention and control is the major priority program that has enjoyed over the years utmost government commitment and considerable attention from the health policy makers since the beginning of HSDP I. The overall strategies to substantially reduce the overall burden of morbidity and case fatality rates remained: comprehensive approach to vector control, early diagnosis and prompt treatment and, surveillance, prevention and rapid management of malaria epidemics when and where it occurs.

The major targets for HSDP III in malaria prevention and control were: to distribute 20 million ITNs to households in malarious areas, increase the proportion of under 5 children utilizing ITNs from 2% to 63%; and pregnant women utilizing ITNs from 2% to 49%, reduction in the malaria morbidity from 22% to 10% and malaria case fatality rate in age groups of 5 years and above from 4.5% to 2% and in the under 5 children from 5% to 2%.

The achievement so far show that distribution of ITNs has successfully reached around 22.2 million in 2008/09 that makes Ethiopia the third highest bed net coverage achiever in Sub-Saharan Africa after Togo and Sierra Leone. [xv] The major proportion of these ITNs are long lasting insecticide treated nets (LLITN) and have been distributed to communities including in hard to reach areas through health facilities, enhanced outreach strategy, and through especial community campaigns. The most effective anti-malarial drug, artemether-lumefantrine, has been introduced nationwide as the first line treatment for Plasmodium falciparum malaria. Access to parasitological diagnosis of malaria has been extended to the peripheral health facilities including HPs through the introduction of rapid diagnostic tests. Indoor residual spraying as vector control measures for the prevention of malaria epidemics has continued to be put into operation. It is important to note that much of the scaling-up in the prevention and control of malaria was mainly community-based, and in particular, basic diagnosis and treatment have been carried out by the HEWs at health post or during house to house visits.

A recent malaria assessment in the country has shown that there has been a 54% and 55 % reduction in malaria admission and death, respectively as compared to baseline period of 2001-2004.[xvi] In-patient case fatality rate of malaria in age group >5 years is 3.3%, while the case fatality rate of malaria in age group <5 is 4.5% .[xvii] Households that own at least one ITN in areas below 2,000m were 65.6% and at least one LLIN were 65.3%[xviii].. Nationally, 55.7% of the households own at least one ITN of any kind, 53.8% own at least one ITN and 53.1% own at least one LLIN. Similarly; In malarious areas, ITN use by children under five years and pregnant women has remarkably leapt from 2.8 and 1.6% to 41.2% and 42.5% respectively[xix].

2.1.2.2 HIV/AIDS Prevention and Control Program

HIV/AIDS prevention and control was recognized as a top priority health intervention from the start of HSDP I. The national HIV/AIDS policy was issued in 1998, and in subsequent years it

was followed by the establishment of a National AIDS Council, National AIDS Secretariat, and other relevant bodies. Notwithstanding, Ethiopia continued facing a mixed HIV/AIDS epidemic amongst the sub-populations and geographic areas.

The estimated HIV prevalence rates for male and female have been 1.8 and 2.8, respectively. Overall, the national point prevalence for 2009 was 2.3[xx]. . During the same year, adult HIV incidence was 0.28 resulting in total AIDS related deaths of 44,751[xxi]. Urban HIV prevalence was 7.7% in 2008 with an estimated 62% of total PLHIV in the country residing in urban areas, while rural HIV prevalence was 0.9%, which accounts for 38% of total PLHIV. Among urban settings, the epidemic varies greatly from 2.4% in Somali region to 9.9% in Tigray, 10.7% in Amhara and 10.8% in Afar regions. Rural HIV epidemic also varies significantly among regions with rural HIV prevalence ranging from 0.4% in Somali region to 1.5% in Amhara region[xxii]. There still exists a challenge of describing the true trend in the incidence and prevalence of HIV due to varying methodologies applied in series of surveys in Ethiopia. In the year 2009, HAPCO, 2007 Single point estimate show that there were around 1,116,216 people living with HIV and of these 336,160 needed ART. There were also a total 855,720 AIDS orphans in the country.

The plan under HSDP III was to achieve provision of VCT/HCT services in 100% hospitals and HCs, PMTCT services in 100% of hospitals and 70% of HCs and increase the number of PLHIV on ART from 13,000 to 263,000. These targets were set to achieve a reduction in the adult incidence of HIV from 0.68% to 0.65% and also maintain the prevalence of HIV at the existing state.

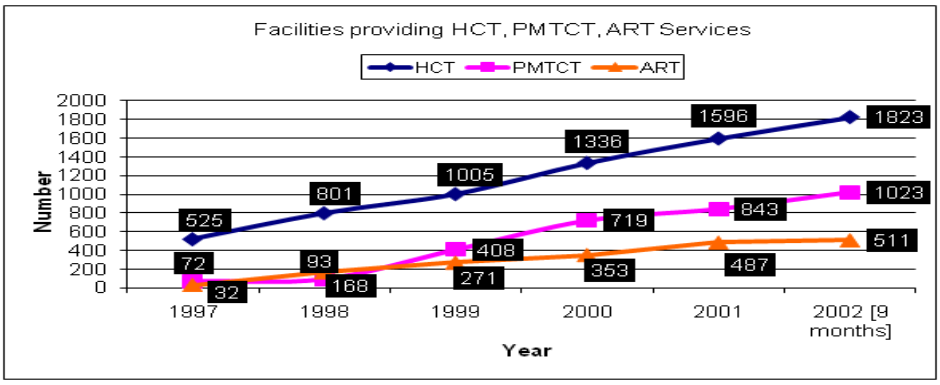


Fig 2.4, Facilities providing HCT/VCT, PMTCT, and ART Services, 2009/10

Recent reports and assessments showed there have been marked increases in the number of health facilities and sites providing HCT, PMTCT, and ART services during the HSDP III period. According to FMoH 2008/09 Administrative report, the increase in health facilities have been from 801 to 1823 for (VCT) HCT, from 93 to 1023 for PMTCT and from 168 to 511 for ART. The number of clients using (VCT) HCT services has gone up to a record of 8,295,483 persons as compared to the 564, 321 in 1998. A total of 6,466 HIV-positive mothers received PMTCT prophylaxis at the end of the fourth year of HSDP III, a performance that only reached 8.2%. The estimate showed that there are 79,184 HIV-positive pregnant mothers and 14,148 HIV-infected births within a year. .

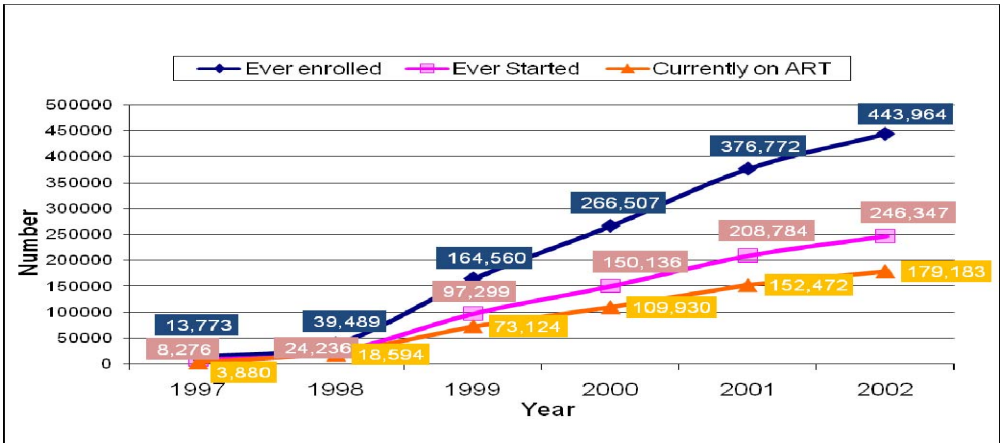


Figure 2.5: Trend in the Actual Number of PLHIV Accessed Care, 1998-2002 (FMoH, 2008/09 Administrative Report and HAPCO, 2010 Report)

Recent Service delivery reports from HAPCO (Feb. 2010) indicates that the number of PLHIV ever enrolled in ART program has increased to 443,964, while those ever started on ART increased to 246,347 and the number of PLHIV on ART reached to 179,183 making ART coverage 53% (percentage of PLHIV currently on ART out of the total eligible) that showed significant progress compared to the baseline of 13,000 in 2005/06. Among regions, the highest proportion of PLHIV enrolled in HIV care is seen in Amhara, Oromia and Addis Ababa While, Harari region manages to enroll far more than the target (122%), and Somali region takes in hand only 13% of the eligible target. Similarly, Beneshangul Gumuz, Dire Dawa, Addis Ababa, and Tigray are the regions that performed well enrolling 66%, 66%, 68% and 73% of targeted eligibles respectively..

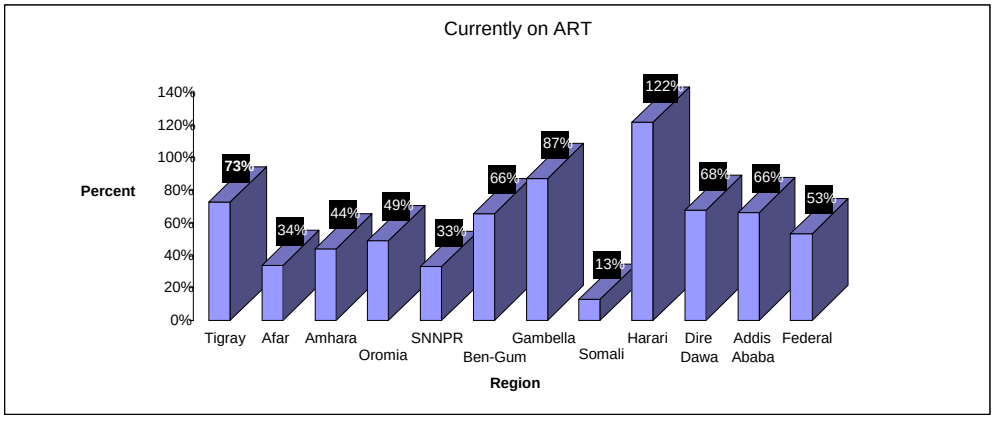


Fig 2.6, PLHIV Currently on ART across regions, 2009/10

2.1.2.3 TB and Leprosy Control Program (TLCP)

Tuberculosis has remained one of the major global public health problems. Ethiopia ranks seventh among the world's 22 high-burden tuberculosis (TB) countries.[xxiii] According to WHO estimates in 2009, incidence ratio of all forms of TB in Ethiopia were 379 per 100,000, while prevalence of TB Infections and mortality rate due to TB in the same year stood at 579/100,000, and 92/100,000, respectively. Prevention and control of TB has created additional challenge and a major strain to health care systems in many of developing countries including Ethiopia due its linkage with HIV/AIDS. WHO recommends a focus on the Three 'I's, isoniazid preventive treatment, intensified case finding for active TB, and TB infection control, to be the key public health strategies to decrease the impact of TB on people living with HIV.

In terms of leprosy control, WHO figures show that the prevalence of leprosy in Ethiopia is estimated at 6 per 100,000 in 2005/2006 with an estimated 4,000-5,000 cases detected every year.

Ethiopia runs an integrated TLCP health care intervention since the beginning of HSDP I. The general objective of the TLCP is to reduce the incidence and prevalence of TB and Leprosy as well as the occurrence of disability and psychological suffering related to both diseases; and to reduce mortality resulting from TB to such an extent that both diseases are no longer public health problems. HSDP III mainly focused on enhancing the detection rate and completion of regularly provided treatment as the main strategy for the prevention and control of TB.

The target set for the prevention and control of TB have been to achieve 85% treatment success rate and a detection rate of 70% of new sputum +ve TB cases. The national cure and treatment success rates are 67% and 84%, which is on track towards HSDP III target, while the case detection rate remains at 34%, far less than what was planned for HSDP III. Regional disaggregation showed highest Case Detection Rate in urban administrations (Harari 95%, Dire Dawa 81% and Addis Ababa 63%); whereas, Somali, Amhara and Tigray regions performed low at 19%, 23%, and 26% respectively. With reference to Treatment Success Rate, except Tigray (79%), Addis Ababa (72%), and Harari (64%) all regions are above the national average, and highest performances were in Afar (92%) and Gambella (89%). In the year 2009/10, 3,465 (35.4%) health facilities out of the 14,329 health facilities (hospitals, health centers, clinics, nucleus health centers and health posts) were providing TB-DOTs service and 879 (7%) health facilities were implementing TB/HIV collaborative activities[xxiv]

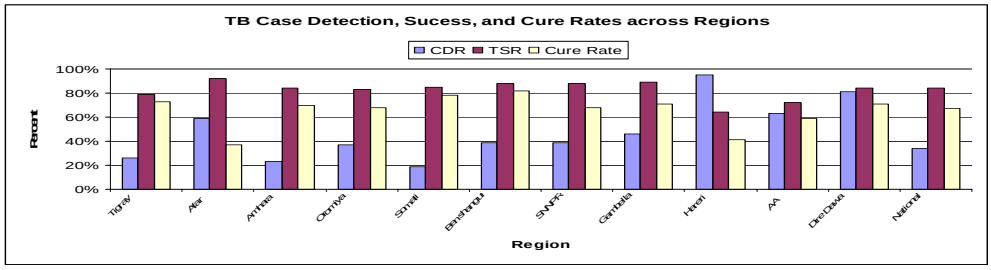


Fig 2.7 TB Case detection, Treatment success and Cure rates, 2008/09

Like Tuberculosis control, leprosy control is based on enhancing the detection rate and completion of regularly provided treatment. There have been improvements in the detection rate

and treatment of leprosy although more effort is required to reduce the prevalence of grade 2 disability from 12% to less than 10% as targeted in HSDP III. There were 3,878 new cases detected in 2008/2009. Reports have also shown that there has been a decline in proportion of grade 2 disabilities among new leprosy cases which was 9% in 2007/2008 with a further decline to 7% in 2008/2009. These figures are still far behind the targets of achieving 2% in HSDP III. In addition, treatment completion rate for Leprosy cases has also reached to 89% from baseline of 82% in 2004/05[xxv].

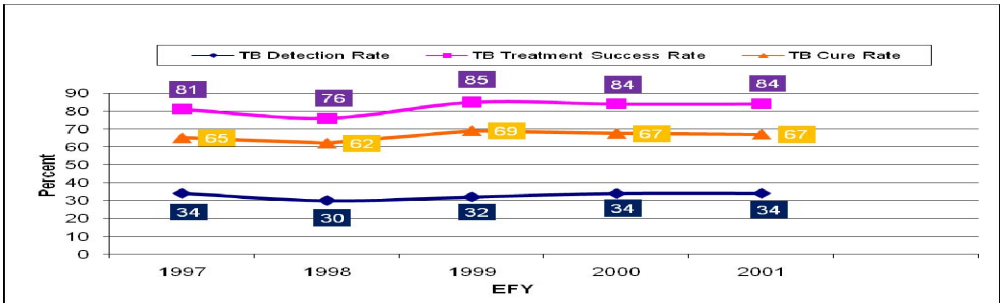


Figure 2.8: Trend in TB Detection, Treatment and Cure Rate, EFY 1997-2001 (FMoH, ARM EFY 2008/09 Report)

2.1.2.4 Blindness Prevention and Control Program

Cataract, trachoma, glaucoma and childhood blindness are the major causes of blindness in Ethiopia. The prevalence of blindness in Ethiopia is 1.6%. There are 1.2 million people with blindness of all causes and 2.8 million people with low vision. Cataract and trachoma constitute more than 60% of all blindness[xxvi] . The main strategy in place for trachoma control is "SAFE", i.e. Surgery, Antibiotics, Facial cleanliness and Environmental Sanitation, including preventive measures.

Major strategic initiatives prior to HSDP III were, launching the Global Initiative on blindness prevention and control, VISION 2020; establishment of a National Eye Bank and development and Standardization of cataract surgeons' training curriculum. Human resource and service delivery in these areas have improved over the years. For example, the number of ophthalmologists increased from 63 to 76 and primary eye care units from 46 to 54; and the number of cataract surgeries also increased from around 20,000 in 2002 to 25,000 in 2004 and 37,000 in 2008/09..

Under HSDP III, the plan was to reduce active trachoma in the targeted 80 Woredas by 80% and increase the Cataract Surgical Rate (CSR) from 350 to 600 per million populations per year. The HSDP III performance report showed that the number of woredas implementing SAFE Strategy for trachoma has reached 124 and about 37,000 cataract surgeries were performed in 2008/2009 making cataract surgical rate of 460 /million/year with achievement rate of close to 60% of the HSDP III target.

2.1.2.5 Onchocerciasis Control and Dracunculiasis Eradication

Ethiopia is amongst the 12 dracunculiasis endemic countries and that also agreed to take concerted actions to interrupt local transmission of the disease by 2009. Nonetheless, 23

indigenous cases were reported in 2009 from Gambella Regional state making it difficult to make progress towards a Dracunculiasis free country.

Concerning Onchocerciasis control program, the plan was to expand the program to all highly affected districts by 2005 and eliminate the disease by 2020. The evaluation of the past performance indicated that the program has been successfully expanded to all the affected districts during HSDP II period. The target under HSDP III has been to achieve a 65% onchocerciasis control in all CDTI areas and ensure the progress and sustainability of the program. The HSDP III performance reports shows that therapeutic coverage for 2008 and 2009 has reached 75% and 77%, respectively. However, it is very imperative for FMOH, RHBs and development partners to revitalize and strengthen their involvement in the control and prevention of Onchocerciasis and Dracunculosis which are most important but remained amongst the neglected emerging tropical diseases.

2.1.3 Prevention and Control of Non communicable Diseases

The target under HSDP III has been to improve the proportion of people seeking care in case of illness or injury from 41% to 55%. With regard to prevalence of injuries, Injuries from road traffic take the lion share and have become one of the major health burdens in Ethiopia. The health sector recognizes that injuries have multiple causes which, with efforts to strengthening the emergency medical services, necessitate multi-sectoral approach towards effective prevention and rapid responses when it occurs..

An assessment report by the FMoH in 2008 has shown that non communicable diseases such as cardiovascular diseases, diabetes mellitus and cancers along with injuries are amongst the major contributors to the high level of mortality and morbidity in Ethiopia. A study finding on the pattern of injuries in Addis Ababa in 2007 has indicated that injuries accounted for 27% of all emergency visits, 5% of all hospitalizations, and 3% of deaths. The findings from a community-based survey in Jimma Zone in 2007 showed that prevalence rate of injury was 8.9% per year and out of the 304 individuals studied, 83.5% had received health care at different levels of health facilities and 5.2% have been admitted for inpatient care.[xxvii]

2.1.4 Integrated Disease Surveillance (IDSR) and Public Health Emergency Management (PHEM)

HSDP-II planned establishing and strengthening integrated disease surveillance in health facilities and at the community level in order to bring significant reduction in incidence of epidemics and outbreaks.

A remarkable frequency and geographic coverage of acute watery diarrhea (AWD) has been observed in the last five years. In addition to impact on human health, the outbreaks did also put significant pressure on other programmes by diverting attention and resources.

Consequently, public health emergency management preparedness and response is one of the core processes introduced under the BPR and implementation has been started. In order to establish PHEM teams at FMOH, and RHBs, 13 epidemic intelligence service officers are being trained at Masters Degree level in Addis Ababa University. Twenty diseases have been selected for surveillance and detection and a new forecasting, early warning, response and record system have been designed.

2.1.5 Hygiene and Environmental Health

The objective of hygiene and environmental Health is to increase the coverage and services to both rural and urban population of the country. HSDP I and II periods saw the development of a National Sanitation Strategy and concerted measures for strengthening the monitoring of water quality by the public sector. During these periods, it also became possible to open two additional International Vaccination Centers at St. Paul and St. Peter TB Specialized Hospitals. There were also some useful achievement records which included access to toilet facilities that was increased from 10 % to 29 % in 2003/2004. The improvement in the access to sanitation facilities was from 12.5% to 17% in 2002/2003. However, the services for hygiene and environmental health have not sufficiently reached the majority of rural population and have been limited largely to urban areas, particularly in some of the regions of the country.

It was during HSDP III that a National Hygiene and Sanitation Strategy and National Protocol for Hygiene have been developed including the commencement in the implementation of Community Led Total Sanitation (CLTS). The HSDP III period also saw the start for a National Millennium Hygiene and Sanitation Movement including the development of mass mobilization and communication strategy. Four regional towns have been selected for the Healthy Cities Program. The work also included the development of Urban Health Service Package with five manuals for the delivery of urban health services.

HSDP III had specific targets for hygiene and environmental health. Some of these are increasing the latrine coverage from 20% to 80% and to reach 100% in the medical and other waste management system in public and private health institutions. Reports so far showed that there has been some significant progresses in latrine coverage which has reached 60%, but fell short of meeting the target[xxviii]. For waste management system it has reached 60%, again very far from the HSDP III target. The other focus for achievement was indicator was reaching 100% in handling and utilization status of existing latrines. The achievement in this regard is not known and is expected to be extracted from the WASH Inventory that was in progress since 2009. Other important activities include the establishment of a committee for infection prevention in public hospitals. The country is also prone to climatic changes resulting in recurrent drought in different parts with potential impact on health of the population and health services infrastructure.

2.1.6 Health Extension Programme (HEP)

The Health Extension program was introduce under HSDP II in 2002/03 with a fundamental philosophy that if the right health knowledge and skill is transferred, households can take responsibility for producing and maintaining their own health. Substantial investments in human resources, health infrastructure, pharmaceutical supplies and operational costs have been made for the successful implementation of the program.

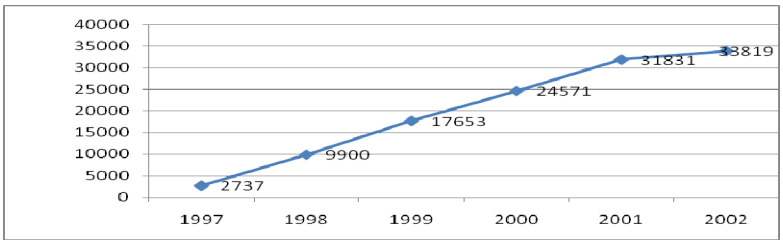


Figure 2.9, Trends in the Training of HEWs, EFY 1997-2002

Under HSDP III it was planned to cover all rural kebeles with the HEP with the aim of achieving universal PHC coverage by 2008 through vigorous and incremental implementation of the programme nationwide. From the very start HEP was supported with the development of 16 different health intervention packages to be delivered by HEWs at community level. These packages along with implementation guidelines were made available to implementers as well as to technical and vocational training institutions. The packages have been subjected to modification commensurate to the life style of the pastoralist population. The training of all female HEWs have been progressing well with encouraging sign and endorsement of community's acceptance and demand for HEP services.

By the end of HSDP III, a total of 33,819 HEWs were trained and deployed surpassing HSDP III target and reaching 102.4 from the required 33,033 HEWs[xxix]. Model households who have been trained and graduated have reached a cumulative total of 4,061,532 from an eligible total of 15,850,457 households. This only represented a coverage of 26% leaving a huge gap of more than 11 million households to be trained and graduate thus requiring a progressive and sustained efforts at all regions and levels of the health care system.

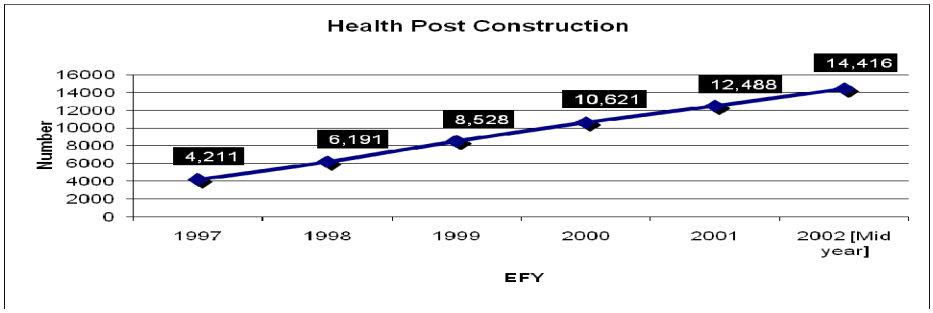


Figure 2.10: Trends of Construction of Health Posts, EFY 1997-2002

In terms of the construction of HPs as a home base for the delivery of HEP at community level, the achievement so far has encouragingly indicate there has been tremendous progress. The total number of HPs has increased from the baseline of 6,191 in 2004/05 to 14,416 in 2009/10, more than doubling in a space of only four years. This figure however showed an achievement rate of 89% compared to the planned target of 100% under HSDP III[xxx]. Equipping Health posts with medical kits remain a major challenge during the implementation years of HSDP III where only 83.1% or 13,510 HPs out the planned target of 16,253 HPs were fully equipped. Other major activities in support of HEP include the establishment of HEP departments at regional levels and respective structures at zonal and woreda levels all aimed at strengthening the management support to HEP.

Technical guideline for HEP Supportive supervision technical, reference books for rural HEP and manuals for school health program were prepared and have been adopted in the light of the BPR. Moreover, implementation Manual for Pastoralist and semi-pastoralist areas was finalized and has been distributed to respective regions. As part of the implementation training and deployment were completed for 2,566 HEP supervisors achieving 80.2% coverage against the plan of 3,200.

In order to expand Urban HEP in seven regions of the country, 15 HEP packages along with implementation manual have been developed and distributed for implementation. Training and deployment of Urban HEWs has already in progress in Tigray, Amhara, Oromiya; SNNP, Harari, Dire Dawa; and Addis Ababa. Accordingly, these regions have trained and deployed a total of 2,319 Urban Health Extension workers achieving 42% of the required number. .

2.1.7 Medical Services

In addition to the construction and expansion of health facilities, the FMOH focused on strengthening the management capacity of health facilities during HSDP III period to ensure the delivery of effective, efficient and quality medical services. The *Ethiopian Hospital Reform Implementation Guidelines* that provide guidance for managers to improve hospital management in areas such as nursing care, facilities and equipment management, human resource management, infection prevention and quality management, among others was launched and similar Guidelines are also being developed for Health Centers as well.

An assessment done in 47 selected hospitals on their performance for the year EFY 2001 showed 50.8% bed occupancy rate (BOR), 27.8% patients per bed per year as bed turn-over rate (BTR), and 6.7 days of average length of stay (ALOS). The same revealed that average cost per patient–day equivalent (PDE) of 196 ETB[xxxi].

With respect to per capita attendance rate, it is difficult to measure progress due to erratic implementation of the new HMIS in regions. Yet an increasing number of indigenous and international NGOs are currently involved in various aspects of service delivery, and there are currently 277 private clinics not for profit and 1,788 private clinics for profit in the country. The total number of hospital beds is 13,922, which mean that there is one bed for a population of about 5,300. This figure is about five times lower than the sub-Saharan African average.

2.1.8 Nutrition

Nutritional disorders are the main causes of morbidity and mortality. The major problems are protein-energy malnutrition and micronutrient deficiencies such as vitamin A, iron, and Iodine. During HSDP I & II, In addition to the efforts by Agricultural and Rural Development Sector which has the role of making adequate nutrition available to the population, the Health Sector initiated enhancing good nutritional practice through health education and treatment of severely malnourished children and prevention of nutritional health problems through provision of micronutrients to the vulnerable group of the population (mothers and children). Nutrition has also been made part of packages of the HEP.

One of the achievements of HSDP III is the development and implementation of the National Nutrition Strategy and programme. To achieve HSDP target of creating access for 90% of children 6-59 months for nutritional screening, nutritional screening is underway every three months at HP level with plan to screen more than 95% of the 6-59 months children. With respect to the plan to increase the proportion of infants 0-5 months exclusively breast fed from 38% to 63%, a study done in four regions of (Amhara, Oromiya, SNNP and Tigray) showed that the prevalence of exclusive breast feeding has reached 76% in 2008/09[xxxii]. .

The proportion of children aged 6-59 months getting vitamin A prophylaxis through two rounds of Vitamin A supplementation per year reached 95% in 2008/09, far above HSDP III target of increasing from 38% to 54%. Transition of the EOS into the HEP started in 39 districts in conjunction with the CBN roll-out. The core package of CBN interventions was implemented in

849 sub-districts of Amhara, Oromia, SNNP and Tigray Regions (surpassing the target of 60% coverage). .

2.2. Health Systems

The following sections summarize progress made in the area of health systems in Ethiopia.

2.2.1. Health Sector Reform

Health sector reform in Ethiopia is an undergoing process as a comprehensive endeavor in the socio-economic reform that started with Civil Service Reform covering the entire public sector of the country. As part of this national effort, the reform in the health sector has been intensified through the application of a new concept known as Business Process Reengineering (BPR). BPR has been used as a tool for a comprehensive analysis, redesign and revamping of the health sector in Ethiopia. As a process itself forms a fundamental rethinking and requires a purposeful and radical redesign of health business processes to achieve dramatic improvements in critical, contemporary measures of performance such as cost, quality, service and speed. The BPR is a country led, multisectoral undertaking implemented as a comprehensive approach to the government's civil service reform. The purpose of the PBR in the context of the health sector was to establish customer focused institutions, rapid scaling up of health services and enhancing the quality of care in order to improve the health status of the Ethiopian people as indicated in the mission of the health sector. Following a deeper and systematic analysis of the "as is" situation at all levels of the health system, including health facilities, the sector has brought in innovative approaches including , benchmarking best practices, redesign new processes, revising organizational structures and a selection of 8 core process and 5 support processes. The new 8 core processes are; Health Care Delivery; Public Health Emergency Management; Research and Technology Transfer; Pharmaceutical Supply; Resource Mobilization and Health Insurance; Health and Health Related Services and Product Regulation; Health Infrastructure, Expansion and Rehabilitation; and Policy, Planning, Monitoring and Evaluation. The 5 support processes designed were: Human Resources Development /Management; Procurement, Finance and General Service; Program-Based Audit; Public Relations and Legal Services.

Subsequent to this, series of training sessions have been given to managers and technicians at all levels, There has been changes in staff deployment and specific job assignments including recruitment of new staff leading to progressive implementations under the close oversight of the top health leadership..

2.2.2. Health Facility Construction and Expansion

Since HSDP I, major activities under the health facility construction, expansion, rehabilitation, furnishing and equipping focused mainly on the PHC facilities: HPs and HCs and to a certain extent hospitals. By the end of HSDP II, the number of public HCs has increased by 70% from 412 in 1996/97 to 519 in 2003/04. For the same periods, the number of HPs increased from 76 in 1996/97 to 2,899. The number of hospitals (both public and private) also increased from 87 in 1996/97 to 126 in 2003/04. There has been also considerable health facility rehabilitation program and furnishing during the HSDP I and HSDP II including improvements in support facilities. As a result, the potential health service coverage increased from 45% in 1996/97 to 64.02% by 2003/04.

The HSDP III plan was to further expand these and other services with the aim of achieving universal health service coverage by the end of 2008 and also improving the delivery of primary

health care services to the most neglected rural population. This was an extension of the Accelerated Expansion of Primary Health Service Coverage that has been launched in the midterm of HSDP II. The HSDP III target in this component has been to attain a 100% general potential health service coverage by availing 3200 HCs through construction, equipping and furnishing of 253 new HCs and upgrading 1,457 HSs to HC level and also upgrading of 30% of HC to enable them perform EmONC services

Table 1: Trends of Health Facility Construction

Facility	HSDP I (1996/7)	HSDP II (2003/2004)	HSDP III (2010)
HP	76	2,899	14,416
HC	412	519	2689
Hospitals	87	126	195

Progresses in the Health facility construction, upgrading and equipping under HSDP III were remarkable. Through increasing construction works, the number of HPs has reached 14,416 achieving 88.7% of the target by 2009/10. . Moreover, there are now 2,689 HCs accounting for 84% of the 3,200 HCs target by the end of HSDP-III. Additional 511 HCs are under construction to reach the 100% target. At the beginning of HSDP III, there were 82 all types of Hospitals (37 District, 39 Zonal and 6 Specialized Hospital). The planned target under HSDP III was to increase the number of hospitals to 89 (42 district and41 zonal). However, the 2008/09 report showed that the target has been surpassed with current total of 111 Public Hospitals (nearly 25% increase).[xxxiii].

In addition, 12,292 health posts have been equipped which represents 75.6% of the target of equipping 16,253 health posts. Equipment for 2,299 HCs was accomplished and for an additional 390 HCs is underway. The rest 511 new HCs under construction will be equipped following their completion. . Moreover, the construction of 21 blood banks in six regions is on progress with 95% of the construction completed in 2009 and the preparation of a National Laboratory Master Plan has also been already completed.

2.2.3. Human resource development

Human Resource Development (HRD) has been a key component in the successive HSDPs. It has been one of the key components in HSDP III with the main objective of improving the staffing level at various levels as well as to establish implementation of transparent and accountable Human Resource Management (HRM) at all levels. It is envisaged that this will be made possible through increasing the number and capacity of training institutions, use health institutions as a training center as well as through establishing a platform for the effective implementation of CSRP and introducing incentive packages.

With the aims of improving the overall HRH situation in the country the government has initiated BPR process that thoroughly analyzed the HRH situation in the country. Based on this a comprehensive HRH strategic plan that details the HRH planning, management, education, training and skill development, legal frame work as well as financing mechanism have also been developed through involvement of relevant stakeholders, development partners and international consultants.

To improve the staffing number and composition at various levels, taking into account the HRH requirement for the universal Primary Health Care (PHC) coverage by the end of HSDP III

period, the focus has been on scaling up the training of community and Mid-Level Health Professionals (MLHPs). With regard to community level professionals a total of 31,831 HEWs have been trained and deployed to meet the HRH requirement for HEP. Similarly, Accelerated Health Officer Training Program (AHOTP) was launched in 2005, in five universities and 20 hospitals to address the clinical service and public health sector management need at district level. So far more than 5,000 health officer trainees (generic and upgrade) have been enrolled and 3,573 Health officers were graduated and deployed. In addition; to address the HRH need for Comprehensive Emergency Obstetric Care (CEmONC) and other emergency surgery service need at PHC level, curriculum for masters program on Emergency Surgery has been developed and training has been started in five universities. To address the critical shortage and mal-distribution of doctors, in addition to the existing medical schools a new medical school that uses innovative approach has been opened in St. Paul's Hospital's Millennium Medical School. A new integrated curriculum that enhances the clinical skill and social accountability of medical doctors has also been developed.

Overall, the available professionals at the end of HSDP III compared to the HSDP III targets shows that the target has been met for community level and most of MLHP. The number has also significantly increased compared to the levels in the previous HSDP. However, there is still major gap with regard to medical doctors, midwives and anesthesia professionals (See Table below) especially when one takes into account the long lead time and limited involvement of private sector in training of these professionals.

Table 2: The total number of available Human Resource for Health during the successive HSDP phases

HR Category	End HSDP I 1994		HSDP II End 1997		HSDP III	
	Total No	Ratio to population	Total No	Ratio to population	Total No	Ratio to Population
All physicians	1,888	1:35,603	1,996	1:35,604	2152	1: 34,986
Specialist	652	1:103,098	775	1:91,698	1151	1:62,783
General practitioners	1,236	1: 54,385	1221	1:58,203	1001	1:76,302
Public health officers	484	1:138,884	683	1:104,050	3,760	1: 20,638
Nurses Bsc, & Diploma (except midwifes)	11,976	1:5,613	14,270	1: 4,980	20109	1: 4,895
Midwifes (Senior)	862	1:77,981	1,274	1: 55,782	1379	1: 57,354
Pharmacists	118	1:569,661	172	1:413,174	661	1: 117,397
Pharmacy Tech.	793	1: 84,767	1171	1: 60,688	3013	1: 25,755
Environmental HW	971	1: 69,228	1169	1: 60,792	1,819	1: 42,660
Laboratory technicians & technologists	1,695	1:39,657	2,403	1: 29,574	2,989	1: 25,961
Health Extension Workers	-	-	2,737	1: 23,775	31,831	1: 2,437

Region	Physician (GP & specialist)	Physician : Population Ratio	Health Officer	HO : Population Ratio	All Nurses	Nurse : Population Ratio	Mid-wives	Mid Wife: Population Ratio	HEW*	HEW : Population Ratio
Tigray	101	1:44,880	188	1:24,111	2,332	1:1,944	185	1:24,502	1,433	1:3,163
Afar	15	1:98,258	29	1:50,823	185	1:7,967	–	–	572	1:2,577
Amhara	304	1:58,567	434	1:41,024	3,790	1:4,698	212	1:83,983	7,471	1:2,383
Oromia	378	1:76,075	448	1:64,189	5,040	1:5,706	287	1:100,197	13856	1:2,075
Somalia	71	1:65,817	12	1:389,415	314	1:14,882	45	1:103,844	1,427	1:3,275
Ben-Gumuz	12	1:59,309	42	1:16,945	452	1:1,575	37	1:19,235	499	1:1,426
SNNPR	242	1:65,817	220	1:72,398	3,980	1:4,002	316	1:50,404	7,915	1:2,012
Gambella	13	1:25,585	13	1:25,585	91	1:3,655	4	1:83,150	457	1:728
Harari	29	1:6,655	31	1:6,226	276	1:699	29	1:6,655	47	1:4,106
Addis Ababa	934	1:3,056	170	1:16,791	3,377	1:845	244	1:11,699	NA	-
Diredawa	53	1:6,796	19	1:18,957	272	1:1,324	20	1:18,009	142	1:2,537
National	**2,152**	**1:36,158**	**1,606**	**1:48,451**	**20,109**	**1:3,870**	**1,379**	**1:56,427**	**33,819**	**1:2,301**

Table 3: Total number of available Human Resource for Health by region, 2009

The above table shows health professional to population ratio in selected key categories of health professionals across regions. Anchored in the recent reports, numbers of health professionals in different parts of the country are lower than what is standard. Especially worsened in agrarian and pastoralist regions. However; the available professionals at the end of HSDP III compared to the HSDP III targets show that the target has been met for community level and most of mid level health professionals. The number has also significantly increased compared to the levels in the pervious HSDPs. However, there is still major gap in highly skilled professionals like Medical doctors, midwives and anesthesia professionals.

2.2.4. Pharmaceutical Services

Since the start of HSDP I, the government was committed to ensuring community's access to the essential medicines that are safe, effective and of assured quality including rational drug prescription and use. In the ongoing health sector reform, ensuring a regular and adequate supply of pharmaceuticals has been considered as one of the core processes in the BPR and the following have been implemented so far.

In order to introduce efficiency in the supply chain of pharmaceuticals and medical supplies management system, PHARMID has been transformed into Pharmaceutical Fund and Supply Agency (PFSA) with the several measures taken to strengthen the capacity of the new agency.

These measures include:

- Deployment of more regular staff and mobilization of TAs.
- Design of the LMIS
- The selection of 18 sites and beginning of the construction of warehouses and hubs.

- Overhauling and strengthening the transport capacity of the Agency through the procurement of 92 trucks.
- Improvement in the RDF volume by making available additional funding.
- Building cold rooms that has increased the national capacity by five fold.

Furthermore; PFSA has developed a national list for the procurement of Essential Pharmaceuticals. It has been able to develop a pharmaceutical forecasting plan in consultation with health facilities that would be required for need-based procurement. The Agency has also undertaken capacity building activities in the areas of drug supply management and also engaged in the establishment and strengthening of Drug and Therapeutic Committees (DTC) in health facilities in order to improve the supply and rational use of pharmaceuticals. The new Agency has already started handling bulk procurement, storage and distribution of pharmaceuticals.

2.2.5. Health and Health Related Services and Product Regulation

A key principle underpinning the design of BPR in the health sector was bringing a significant improvement in the quality of health services through the institutionalization of accountability and transparency. One mechanism of achieving this was to seriously consider the separation of purchaser, provider and regulator in the health system. As part of this important endeavor, the former Drug Administration and Control Agency (DACA) has undergone an institutional transformation into a new Agency called Health and Health related Services and Product Regulatory. The mandate of the new agency is to undertake inspection and quality control of health and health related products; premises, professionals and health delivery processes in an integrated manner. The Agency is strengthened through the construction of new building at federal and branch offices at regional levels that helped the Agency to expand the drug administration and control system throughout the country. The agency has now five branch offices which it provided delegation to RHBs on drug administration and control.. The agency is working closely with RHBs on drug quality and rational use through the process of reviewing drug documents, physical and laboratory quality assurance checks. Prevention and control on the use of narcotic drugs including tobacco are other mandates of the Agency which it works collaboratively with appropriate government offices. The agency has recently procured, installed and commissioned for use modern equipment for the safe disposal of expired drugs.

2.2.6. Harmonization and Alignment

Major objective under harmonization and alignment is putting in place One-Plan, One-Budget and One-Report at all level of the health system. It refers to how the set of actors in the sector should work together with respect to harmonizing and aligning their actions and procedures with the country's systems. A Code of Conduct instrument between the FMOH and its major Health development Partners was signed in 2005 to guide the conduct of all partners in support of HSDP. Afterwards, an operational manual entitled "HSDP Harmonization Manual" that focuses on ensuring one-plan, one-budget and one-report at all levels of the health system has been developed and endorsed by all stakeholders in 2007. Ethiopia has been one of the signatories of the Global IHP+ Compact and a first country to develop and sign a Country based IHP+ Compact.

2.2.6.1. One Plan

The Government has produced and continued the implementation of a comprehensive National socio-economic development plan called "the Plan for Accelerated and Sustained Development to End Poverty-SDPRP". This is a single national plan which guides all other sectoral plans for the years covering 2005/06-2009/10. HSDP is also a health sector wide strategic plan which is the product of intensive and substantial consultations between the Ministry of Health and the Health Development Partners. In 2005, the Ministry of Health and its partners developed HSDP III as a single program framework, one plan, for coordinating health interventions aligned with SDPRP. The goals, targets and costing of HSDP-III are aligned with health MDGs.

One of the most important refinements in the HSDP III has been the inclusion of "Woreda Based Health Sector Planning" which has brought an additional value and a breakthrough in the health planning system for ensuring vertical and horizontal alignments in the health intervention priorities of the sector. For four consecutive years covering 2006/07, 2007/08, 20008/09 and 2009/10, woreda based health sector plans have been prepared in line with the principles of "one plan, one budget, and one report" of the HHM based on the agreed priorities and targets. This planning system created a platform for joint planning by all stakeholders at all levels of the health system including health development partners. This exercise has also improved the capacities of Woreda health offices in conducting evidence based planning that in the course of time have shown remarkable results.

2.2.6.2. One Budget

The principle of "One budget" in HSDP III and beyond means all available funding for health activities (government and donor sources) are effectively pooled and should flow through government channels. Another important feature of the one budget principle is all of these funds for health activities should be reflected in only one plan and one documented budget, although actual funding disbursement may be effected through separate channels. Subsequent to the signing of the IHP+ Compact, a joint decision between the FMOH and the health development partners has led to undertaking an independent assessment of the health system focusing on financial administration, procurement, equity and social inclusion with an intention of filling the prevailing resource gaps. This assessment has resulted in the establishment of the MDG Performance Fund which was the hallmark towards reaching an agreement for a one-budget framework in the health sector of Ethiopia. The key findings of the assessment were capacity limitations at PPFGD, Finance and Audit section of the FMOH, and PFSA that impeded efforts to enhance performances as per the requirement of the reform design. Another finding was the slow pace in the scaling up of HMIS and M&E. Relevant recommendations have been forwarded for mitigating these challenges and have been documented as part of POA of FMOH. Furthermore, FMOH and Development Partners have developed a Joint Financing Arrangement (JFA) for the establishment of the MDG Performance Fund that has been signed by Seven Development Partners which has led the FMOH accessing and make use of the pooled funds.

In addition, the FMOH in collaboration with development partners have started the formulation of MTEF. The main purpose of the MTEF is to help the health sector at all levels in determining and allocating available domestic and external resources for HSDP IV priorities. It is also seen as a useful instrument for negotiations with the Ministry of Finance and Economic Development (MoFED) as well as a tool for advocacy for the mobilization of increased external resources. A coordinating committee for MTEF has been established and a continuous process of

communication and coordination is undergoing across the various institutions at the federal and regional levels including MoFED, and some milestone activities have been completed. Among these activities, resource mapping and gap analysis at federal level has been completed. If not all, many development partners have disclosed their three year resource commitments to the health sector. Similar activities are on progress at Woreda level where resources from local governments, NGOs and other organizations are expected to be captured in the one plan framework. It is expected that the process will be completed soon and will be available in time as an important input for the development of HSDP IV.

2.2.6.3. One Report/One M & E

Establishing HMIS at all levels of health service delivery system and setting up HMIS units at all levels for ensuring information use for evidence-based health planning and decision-making were the major targets that were set during HSDP-II. Subsequently, HMIS national advisory committee (NAC) was established with representation from different stakeholders and had been instrumental in facilitating the design and pilot testing of the new HMIS during HSDP III. HMIS has been redesigned and was pilot tested. Scaling up the new HMIS to all regions has started after the development of detailed implementation plans by RHBs. FMOH printed and distributed HMIS tools to regions after a thorough assessment in the readiness for implementation. HMIS Resident Mentors have been deployed to implementing regions. Electronic Medical record (EMR) has been pilot tested in a hospital setting and is now ready for scaling up at the national level.

As part of the BPR, integrated supportive supervision, operational research, performance review and quality assurance and inspection have been added to complete M&E in the strategic planning of the health sector. Implementation manuals, tools and system requirements for implementation has been finalized. Joint Performance reviews such as ARM and JRM were also undertaken according to the plan and Annual Review Meeting (ARM) has been conducted every year and the level of Completeness in the annual HSDP report has shown significant improvements over the HSDP III periods.

2.2.6.4. Governance of HSDP

FMOH-RHBs joint Steering Committee, FMOH-HPN Joint Consultative Forum and the Joint Core Coordinating Committee have been functioning very well. The FMOH-RHBs Joint Steering Committee that is chaired by the Minister meets regularly (every two months) to promote and monitor the implementation of HSDP Harmonization Manual and Civil Service Reform agendas (BPR) amongst other strategic objectives of the HSDP III.

The CJSC, which is the top policy decision-making and governance body of the sector meets far less often while the FMOH-Donor Joint Consultative Forum and JCCC meetings on the other hand have been regularly functional with the JCCC focusing on technical and operational issues.

2.2.6.5. Health Care Financing

As it has been clearly indicated in the 4th National health Accounts (2010), health service in Ethiopia is primarily financed from 4 sources: the federal and regional governments; grants and loans from bilateral and multilateral donors; non-governmental organizations and private contributions. Although it has significantly improved over the years, health care financing

remain a major challenge for the health care system of Ethiopia. Since HSDP III, a health care financing strategy was adopted by FMoH, mainly focusing on improving the efficiency of allocation and utilization of public health resources, mobilization of additional resources from international donors and health development partners, retention and utilization of user fee revenues at health facility level, introducing private wings in the public hospitals and, more importantly, an initiation in the development of risk sharing mechanisms in the form of public and community-based health insurances..

The objective of health care financing component of HSDPs center on the mobilization of increased resources to the health sector, promoting efficient allocation, effective expenditure for allocative equity and utilization of the available health resources, aimed at achieving a sustainable health care financing system.

Since HSDP I, there have been a number of background studies on health care financing issues that have contributed to the introduction of reforms and strategies that were closely monitored and evaluated. Since the first HSDP, four National Health Accounts (NHA) have been conducted. A Proclamation on Health Service Delivery, Administration and Management including five regulations on all the components of the reform were drafted and endorsed. RHBs of Tigray, Amhara, Oromiya, Benishangul-Gumuz, SNNPR, and Addis Ababa translated most of the reforms into action. The reform components include: retention and utilization of revenue, administration of the fee waiver system and establishment of functioning facility governance bodies. Outsourcing of non-clinical services, establishment of private wing in health facilities and exemption of certain services have also been a part of the reform and on process of implementation at the national level..

2.2.6.6. Retention and Utilization of Revenue

Ratification of the Health Care Financing Reform proclamation and regulation by the regional governments and City Councils are the initial steps for the commencement of user fee revenue retention and utilization at health facility level. To assist the implementation, a number of generic operational manuals have been designed to be used, if needed with modifications, for the implementation of the reform as seen fitting to the local conditions. The manuals describe in details the process of user fee revenue collection, financial administration, accounting, auditing and procurement of goods and services. Moreover, establishing a functional health facility governance board with key representatives from health, finance, community and other relevant sectors is a fundamental requirement of the reform. The board meets on regular basis and decides on the use of the retained revenue for the eligible expenditure areas as broadly described in the operational manual.

The performance report for the health care financing report showed that up to the end of 2008 (EFY 2001) 73 hospitals and 823 health centers have started retaining revenue and 95% of them utilized the user fee revenue they have collected. This shows that the utilization rate of the revenue from user fees by these facilities is encouragingly high.

In terms of achieving the target of retention and utilization of 100% of revenue generated at hospitals and HCs, the report showed that out of 172 potential hospitals, 73 (42.4%) and out of 2,193 health centers 823 (37.5%) have been able to collect user fee revenue in 2008/09. Of these, 66 (38.4%) and 782 (35.6%) utilized their collected revenue, respectively.

2.2.6.7. Health Insurance

To start the whole process of establishing and institutionalization of an insurance system in Ethiopia, studies and experience sharing visits were undertaken to various African, Latin American and Asian countries. The background document on Social Health Insurance (SHI) constitute policy and technical recommendations detailing eligibility to membership, premium levels, the benefits packages and the institutional structure for the establishment of the Federal Social Health Insurance Agency (FSHIA). Looking at the health care financing mechanism in Ethiopia, one can easily observe the significant contribution of out of pocket payment. As per the fourth National Health Account study conducted in 2009/10 based on 2007/08 data, households contribution mainly from out of pocket payment constitute 37% of the total health expenditure. Such financing mechanism is regressive & impedes access to health services. In order to address this problem & create equitable financing mechanism, the government of Ethiopia is currently undertaking a number of activities to introduce health insurance with the overall objective of achieving universal access. To this effect, a health insurance strategy has been developed by the Federal Ministry of Health. According to the strategy, two types of health insurance i.e. social health insurance & community based health insurance will be implemented to cover the population. Social health insurance will cover employees in the formal sector which is mainly payroll-based while community based health insurance covers the rural population & the informal sector in urban areas. To date, a draft law and regulation have been revised and presented for policy and technical discussions. Series of consultative discussions have been conducted in Addis Ababa and the regions. The legal framework has been improved based on the inputs from the various stakeholders and have submitted to the Council of Ministers for the second time for its endorsement and for the subsequent ratification by the Federal Parliament. The SHI Proclamation has finally been approved by the Council of Ministers and endorsed by the House of People's Representatives..

Parallel to the work on social health insurance, various activities are being undertaken including pilot the community-based health insurance (CBHI). The community based health insurance (CBHI) which will cover more than 83.6% of the population is planned to be implemented in two stages. First it will be piloted & then scale-up thorough out the country based on the lesson drawn during the pilot period. Thirteen Woreda's have been selected for this purpose in the four pilot regions (Tigray, Amhara, Oromiya and SNNPR). Preparatory activities for piloting of CBHI schemes in 13 districts (covers 1.45 million population) have been finalized and schemes are expected to provide services to its members in the early 2011. A detailed three year plan has been prepared for implementation and evaluation of CBHI pilot. Training manual has been developed for regional and Woreda level CBHI leadership. A Regional Steering Committee has been established in three of the four pilot regions, while adequate preparations have been made in Amhara Region to establish the committee. To ensure the acceptability and sustainability of the CBHI, feasibility studies have been made in the four pilot regions and the reports of the studies have served as inputs to the whole process of designing the scheme.

After the implementation of the pilot period, CBHI will be scaled-up starting year 2013/14 and it is expected to cover about 40% of the population (35.32 million) at the end of the HSDP IV

period- in 2014/15 and the revenue collected in the form of premium from members excluding subsidies from government will reach USD 73.68 million per annum[1].

With regard to social health insurance, proclamation has been approved by the Parliament in July 2010 and other preparatory activities are being undertaken to start its implementation in July 2011. The regulation which contains the detail features of the health insurance scheme including membership, benefit package, institutional arrangement, etc has been prepared and is ready for public consultation. Once consultation is undertaken & feedback is incorporated, it will be submitted to the Council of Ministers for approval before the end of 2010. During the initial three years starting from 2011/12, the SHI scheme is expected to cover about 7.77% of the population (6.36 million). With the inclusion of the private sector, at the end of HSDP IV, it will cover 10.46% (9.24 million) of the population and resources generated will reach USD of 77.058 million per annum[2].

In summary, both the community based health insurance & social health insurance will cover about 50% of the population at the end of the HSDP IV period. This will definitely reduce financial barrier & improve access to health services by reducing out of pocket expenditure share from its high level of 37 % in 2007/8.

2.2.6.8. Trend of Expenditure in the Health Sector

The finding from Ethiopia's fourth National Health Accounts (NHA, 2010) showed that national health expenditure has grown significantly from the 2004/05 level of 4.5 Billion Birr (USD522 million) to Birr 11.1 billion (USD 1.2 billion) in 2007/08. In terms of per capita health expenditure, the increase has been from the 2004/05 level of USD7.14 to USD16.09 in 2007/08. The report also provided the proportion of health expenditure by each source of financing in the order of 40% by the rest of the world followed by 37% by household out-of-pocket expenditure, the Government (both central and regional) 21% and the remaining being covered by a combination of employers based insurance schemes and other private sources. Official government reports monitoring health expenditure showed that over the years the share of government health budget allocation as a total government budget during the PASDEP period has shown some sign of improvement. For example, health budget allocation as a proportion of received regional public block grant from federal government accounted for 10.1% in 2008/09.

[1] The projection is based on the feasibility studies undertaken to implement CBHI in the pilot woredas.

[2] Financial sustainability study for the social health insurance scheme in Ethiopia, 2010

However, health care funding still remain a continued challenge for the health care system of Ethiopia prompting to an inward and outward looking for the mobilization of additional health resources such as community and social insurance schemes, enhancing in the user fees revenues and increased mobilization of funding from external sources-global and health development partners.

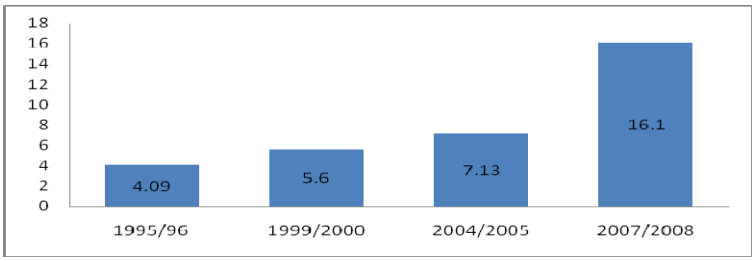


Figure 2.11: Trends of Health Expenditure in USD/Capita

2.2.7. Pastoralist Health Service

Pastoralist population in Ethiopia constitutes about 10% of the total population of the country. Yet, there is Lack of appropriate health service delivery package to address the health care needs of the communities in the Pastoralist regions. This has prompted to establish two core objectives under HSDP-II regarding the Pastoralist health services and systems. These were to establish an appropriate health service delivery for the pastoralist population and to increase coverage and utilization of health services in pastoralist population. In this regard, a concept paper, "Health Service Delivery to Pastoralists", was developed by FMOH and the 16 HEP packages were tailored to pastoralists needs and have been translated into local languages. In addition, as part of government's effort to give technical assistance to the emerging regions, a board composed of members form six ministries was established under the Ministry of Federal Affairs including a technical committee for the integration of support to the Newly Emerging Regions.

Following the redesign and implementation of CSRP and the BPR, one of the major organizational transformations in the FMoH was the establishment of Pastoralist Health Promotion and Disease Prevention Directorate to focus and draw attention to this pastoralist population.

2.2.8. Operational Research

Operational research in health is very crucial to identify priority health and operational problems by producing evidences for planning and decision making for improving health services. Although it is a critical part of M&E, operational research has not been conducted in a coordinated manner during the HSDP I and II periods. Research and Technology Transfer is one of the core processes redesigned as part of the BPR. There have been a surge in the number of operational researches during HSDP III covering wide areas such as on the causes of maternal mortality (Maternal death audit), prevalence of cervical cancer, coverage of child and TT immunization, coverage and impact of the expanded program of immunization, EPI coverage survey, effect of Misoprostol, choice of family planning, nutritional surveillance, traditional medicine, HIV/AIDS, TB, and malaria, surveillance of major public health problems and health commodity tracking. Operational researches were also conducted on the EOS coverage

validation survey, national nutrition baseline survey, effectiveness of Coartem, effectiveness of residual DDT spray, and cost of health services.

2.3. Cross cutting issues

2.3.1. Gender

Gender is among the cross cutting issues and has remained a crucial concern that has prompted the setting of clear objective for gender mainstreaming at all levels of the health system. In this regard, the government has completed the preparation of a training manual on physical violence and analytic framework on gender and health, compilation and analysis of data on female workers to be used for advocacy purposes. The final version of this document will be published and distributed to stakeholders..There has been also a rapid assessment aimed at prevention of physical abuse on women and on the provision of adequate health services for the victims of abuse. Based on the results of the assessment and the identified gaps, a draft training manual has been developed for use by health workers. This training manual has been further refined through a consultative workshop attended by all concerned stakeholders

Chapter 3 Health Sector Development Program IV

3.1 HSDP IV Planning Process, Methodologies and Guiding Principles

Preparation of HSDP-IV has been guided by a concept note and a TOR developed jointly and agreed upon by the Government and Health Development Partners. The Executive Committee of the FMOH and the Joint FMOH and RHB Steering Committee has led the process at the highest levels. These Committees have selected the strategic themes and strategic objectives to be used as a guide and framework for the development of HSDP IV. Subsequently, multidisciplinary teams have been established to prepare the draft document based on the guiding framework. The first draft produced by the multidisciplinary team was discussed by the Executive Committee of FMOH and the Joint FMOH and RHB Steering Committee, which is then shared with all stakeholders for their feedback and it has subjected to two rounds of Joint Assessment for National Strategies (JANS).

At the onset, the Government has made a decision to develop the strategic plans for HSPD IV using the Balanced Scorecard (BSC) framework for which the leadership and team members have taken appropriate training. BSC was seen as a strategic planning and management system designed to help everyone in an organization understand and work towards a shared vision and strategy. The expectation is that a completed scorecard system can potentially align the organization‘s shared vision with its business strategy, desired employee behaviors, and the day-to-day operations. Moreover, strategic performance measures could be used to better inform decision making and show progress toward desired results. The organization can then focus on the most important things that are needed to achieve its vision and satisfy community, stakeholders, and its employees. Other additional benefits include the identification of more efficient processes focused on stakeholder needs, improved on initiative prioritization, on internal and external communications and on linkage between budgeting and cost control processes and strategy.

The basic steps that has used to prepare HSDP IV using BSC includes: a) Conduct Organizational assessment, b) Setting of Strategic elements, c) Setting of Strategic Objectives, d) Prepared Strategic Map of the Objectives, e) Indicated performance measures & Targets of the strategic plan, and f) Prepared the Strategic initiatives that have expected to achieve the overall strategic plan

The other methodology used has been the Marginal Budgeting for Bottleneck (MBB) approach. UNICEF and World Bank have provided technical support on this. MBB enables to systematically look into the health system bottlenecks, high impact interventions, different scenarios and associated costs of achieving results that were planned under HSDP IV. It is planned that the final draft HSDP IV document will be presented to the Government (Council of Ministers and Parliament) for review and endorsement. Upon approval by the highest body of the government, HSDP IV will become an official document and an important input to the Development and Transformation Plan (DTP).

HSDP IV is a policy implementation strategic document that guides the development of sub national plans and sets the rule of engagement in the health sector for the next five years. In order to realize this, the following principles have been applied in the development of HSDP IV.

- Government leadership.
- Enhanced responsiveness to community health needs
- Extensive consultation and consensus with stakeholders.
- Comprehensive coverage of priority health sector issues.
- Linkage between HSDP IV with sub-national HSDPs and strategies/Programs on health priorities and targets

3.2. The Policy Framework

Health care is one of the crucial components of basic social services that have a direct linkage to the growth and development of a country as well as to the welfare of a society.

3.2.1. National Policies and Strategies

National Health Policy and other national policies and strategies have been taken into account in the design of HSDP IV.

The National Health Policy is an overarching policy document that gives strong emphasis to the fulfillment of the needs of the less privileged rural population that constitutes about 83% of the total population in Ethiopia. The Health Policy outlines:

- Democratization and decentralization of the health system;
- Development of the preventive and promotive components of the health service;
- Ensuring accessibility of health care by all population;
- Promoting inter-sectoral collaboration, involvement of the NGOs and the private sector; and
- Promoting and enhancing national self- reliance in health development by mobilizing and efficiently utilizing internal and external resources.

Having the national health policy as an umbrella for the development of HSDP IV, other health and health related policies and strategies have been considered. These include:

- Policy and Strategy for Prevention and Control of HIV/AIDS
- The National Drug Policy
- The National Population Policy
- The National Policy on Women
- Child Survival Strategy
- National Nutrition Program
- National Strategy for the prevention, control and elimination of malaria
- National TB prevention and control strategy
- Development and Transformation Plan (DTP)
- Rural Development Policy and Strategy

- Reproductive Health Strategy
- Health Extension programme
- The Capacity Building Strategy and Programme

3.2.2. International Policies and goals

The most influential International commitments that have providing direction to the HSDP IV are the global declaration of MDGs, the African Health Strategy 2007-2015, the Paris Declaration on Aid harmonization (20050, Accra Accord on Aid effectiveness (2008) and the Abuja Declaration on health care financing in Africa.

HSDP IV is the expression of the GOE renewed commitment to the achievement of MDGS as one of the top Global Policies that is influencing the national development policies and strategies. MDGs that are relevant and directly linked to the health sector include goals 1, 4,5, 6,7and 8. Of these goals, three of them particularly fall under the domain of the health sector with specific targets calling accelerated health interventions.

The design and content of HSDP IV therefore takes stock of the Health MDGs by giving utmost attention to the prevention and control of poverty related diseases.

3.3. Health Sector Strategic Assessment

3.3.1. Mandate Analysis

The mandate of an organization is usually codified in laws, regulations, decrees, or characters. Mandates are formally defined in the Ethiopian laws and regulations for public organizations such as the FMOH and RHB by the legislative body. As the health sector is a collection of organizations, mandates are rather defined for specific organizations than for the whole sector. Therefore, the following topics describe the formal mandates of these organizations. On top these, additional recommended mandates have been identified from the Federal and Regional Strategic plans which are briefly pointed out in here.

3.3.1.1. Roles of Federal and Local Governments

3.3.1.1.1. Mandates of the Federal Ministry of Health

Proclamation No. 475/1995 of the Federal Democratic Republic of Ethiopia provides definition of Powers and Duties of the Executive Organs. This proclamation, in part 3 No. 10 states the common Powers and Duties as follows:

- Initiate policies and laws, prepare plans and budget, and upon approval implement same;
- Ensure the enforcement of laws, regulations and directives of the Federal Government;
- Undertake studies and researches;
- Enter into contracts and international agreements in accordance with the law;
- Give assistance and advice as necessary to Regional executive organs.

Specific duties and responsibilities bestowed upon the Federal Ministry of Health include:

- Causing the expansion of health services;

- Establishing and administering referral hospitals as well as study and research centres;
- Determining standards to be maintained by health services, except insofar as such power is expressly given by law to another organ, issues licenses to and supervise hospitals and health services that are established by foreign organizations and investors;
- Determining the qualifications of professionals required to be engaged in public health services at various levels, provide certificates of competence for same;
- Causing the study of traditional medicines, organize research and experimental centres for same;
- Devising strategies, means and ways for the implementation of prevention, control and eradication of communicable diseases;
- Undertaking the necessary quarantine control to protect public health;-
- Undertaking studies with a view to determine the nutritional value of food-

In addition to the mandate of FMoH, there are four authorized Agencies under the FMOH which are given specific mandates. These mandates mainly focus on ensuring safety, efficacy, quality and proper use of drugs; improving the knowledge, attitude, behaviour and practice of the population on prevention and control of disease and healthy life style; conducting public health and nutrition researches and studies that will contribute to the improvement of the health of the population. The autonomous health institutions report both to FMoH and to MOFED.

3.3.1.1.2. Mandates of the Regional Health Bureaus

Regional Health Bureaus have the powers and duties to:

- Prepare, on the basis of the health policy of the country, the health care plan and program for the people of the region, and to implement same when approved;
- Ensure the adherence of health laws, regulations and directives issued pertaining to public health in the region;
- Organize and administer hospitals, health centers, Health Posts, research and training institutions that are established by the regional government;
- Issue license to health centers, clinics, laboratories and pharmacies to be established by NGOs, OGAs and private investors; supervise same to ensure that they maintain the national standards.
- Ensure that professionals who are engaged in public health services in the region operate within the prescribed standards and supervise same;
- Ensure adequate and regular supply of effective, safe and affordable essential drugs, medical supplies and equipment in the region;
- Cause the application, together with modern medicine, traditional medicines and treatment methods whose efficiency is ascertained; -
- Cause the provision of vaccinations, and take other measures, to prevent and eradicate communicable diseases;-
- Participate in quarantine control for the protection of public health; and

- Ascertain the nutritional value of foods.-

3.3.1.1.3. Mandates of Woreda Health Offices

The mandate of woreda health offices is to manage and coordinate the operation of the primary health care services at woreda levels. They are responsible for planning, financing, monitoring and evaluating of all health programmes and service deliveries in the woreda.

The division of duties and responsibilities between the federal, regional and woreda in the management of and control of health providers include, among others:

- FMoH is responsible for referral hospitals and the national level study and research centres;
- RHBs are responsible for all types of hospitals in the region, health centers and health clinics as well as for health professional training institutions that are established by the regional government;
- WHO are responsible for primary health care services: Health Centers, Health Posts.

3.3.1.1.4. The Role of Administrative Councils

In addition to FMOH, and the line institutions at sub national level, the regional, zonal and district administrative council will play crucial roles in the implementation of HSDP IV. Some of these include:

- Providing political leadership for health.
- Ensuring the community's demand for health care is properly addressed.
- Planning, resource mobilization and allocation, monitoring and evaluation of health programmes and the delivery of health services.
- Facilitating inter-sectoral collaboration.
- Provide guidance to enhance the partnership with NGOs, CSOs, private sector etc

3.3.2. Mission

To reduce morbidity, mortality and disability and improve the health status of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services via a decentralized and democratized health system.

3.3.3. Vision

To see healthy, productive, and prosperous Ethiopians

3.3.4. Core Values of the Health Sector

1. Community first
   - We are here for nothing but to serve and satisfy our community.
   - We treat them as we would like to be treated.
   - We have three priorities: Community, Community, and Community.
2. Collaboration

- We work together in a spirit of mutual support and understanding to achieve our collective goals.

3. Commitments
   - No matter what challenges we face and discomforts we feel, we stand firm, be patient and exert our utmost and sustained effort to achieve our goals.
4. Change
   - We innovate new ways of doing things and be open minded to reforms.
5. Trust
   - We ensure maximum vulnerability and integrity to each other.
6. Continued Professional Development
   - Education, professional behavior and ethics, competence and performance in work duties

3.3.5. SWOT Analysis

Analysis of strengths, weaknesses, opportunities and threats is a crucial step in the planning process. Prior identification of weaknesses and threats help to identify relevant strategies for internal improvement and for the mitigation of factors that may have adverse impacts resulting beyond the control of the health sector. Recognition of strengths and opportunities facilitate ripping of maximum benefits from internal and external environments in order to achieve the goals and targets set in HSDP-IV. The table below provides a summary of the strengths, weaknesses, opportunities and threats in the health sector.

SWOT Analysis of the Health Sector

Enablers	**Pains**
Strengths:	**Weaknesses**:
• High coverage of Health Extension Program • Adoption of cost effective strategies (RBM, MPS, IMCI, DOTS, etc • Successes in the prevention and control of malaria • Increased coverage of ART • Sustained High coverage of EPI • Accelerated training of Health professionals • Rapid expansion of health centers and health posts • Finalization of BPR in the sector • Commencement in the use of IT for telemedicine, tele-education, electronic medical records etc • Increased supply of medical equipment • Increased allocation and expenditure on health • Improvement in the harmonization and alignment • One plan streamlined in the sector • MDG Fund established to enforce one budget • progress in the national HMIS scaling up as part of one M&E framework • Well defined HSDP Governance (CJSC, RJSC,etc)	• Inadequate capacity to implement decentralized health system • Inadequate follow-up on implementation of policies, guidelines, standards and protocols • Low utilization of health services • Weak referral system; • Slow and erratic implementation of BPR • Outdated health facility standards & Low health service quality • Low coverage of Skilled delivery & Newborn care, TB case detection, PMTCT • Inadequate attention to NCDs and NTDs • Inadequate management and support to PMTCT services, TB-Leprosy control at sub-national levels. • Inadequate water supply and WASH to Health facilities, schools, and communities • Inadequate capacity of preparedness to efficiently respond to threats of epidemics such as Malaria. • Lack of Health infrastructure maintenance capacity (Building, Medical equipment, IT) • Shortage of drugs, medical supplies, equipment, and commodities & Slow implementation of Health Commodities Supply System (HCSS) • Weak regulatory system of pharmaceuticals and medical supplies • Inadequate coordination mechanism for public private partnership in health • Weak implementation of HSDP governance (such as the CJSC) • Inadequate quality of trainings and Low performance in training and deployment of model families; • Lack of HR motivation and retention strategy and absence of

Enablers	Pains
	standardized CPD programs • Shortage and attrition of highly skilled professionals • Lack of carrier development for HEWs & Poor coordination in the in-service trainings to HEWs by various partners. • Weak M&E and use of information for evidence-based decision making at lower levels • Persistently inadequate and inequitable distribution of resources compared to needs and priorities (Eg Health system, MNCH, & Health Infrastructure Expansion) • Weak financial management in the health sector including inadequate capacity for fund liquidation, reporting and auditing (Prominent on HIV/AIDS funding). • Poor progress in adopting common budgetary framework and reporting format by DPs • Slow response of many DPs to join the IHP Compact and JFA • Poor predictability and disbursement of committed funds (55.4% in EFY 2001) by DPs
Opportunities:	**Threats**
• Availability of coherent and pro-poor development policy including health • Democratization and decentralization of the health system • Availability of sound health policy • Increasing community participation • Increasing national income; • Health is accorded priority by the Government • Increasing human resource output via the capacity Building Programme • Increasing domestic manufacturing capacity of drugs; • Increasing education of girls • Emerging global health initiatives • Expansion of the private sector • Increasing external resources and TA • Expansion of infrastructure (road, ITC, electricity	• Poverty and high level of population growth • Instability of neighboring countries- • Newly emerging pandemics • Manmade and natural disasters • Adult –illiteracy • Global Financial crisis (rising cost of pharmaceuticals, supplies etc) • Poor aid effectiveness • Brain drain, high turnover of health staff, especially medical doctors

3.3.6. Stakeholder Analysis

Stakeholders are individuals, organizations or agencies that could influence or be influenced positively or negatively during implementation of HSDP-IV. Stakeholder analysis process of scrutinizing the essence, interests, behaviors, and the nature and level of impact brought about by these stakeholders. The degree of influence from stakeholders varies depending on their span of control over the generation and allocation of resources; level of political power; scope of participation in the sector; and range in the use of services provided by the sector.

The attainment of missions and objectives of HSDP- IV is largely dependent on the collective efforts and roles played by the different stakeholders. Therefore, stakeholder analysis in HSDP-IV is a critical issue that helps to define the boundaries of all actors in the health system; clarify contributions expected from each actor; and describe areas of possible collaboration to create synergy to achieve the strategic objectives set in HSDP-IV.

Table 2: Stakeholders Analysis

Stakeholders	Behaviors We Desire	Their Needs	Resistance Issues	Their Influence	Institutional response
Community	• Ownership • Healthy life style	• Empowerment, • Information • Access to quality of health care • Stewardship	• Dissatisfaction • Opting to unsafe alternatives • underutilization	High	• Ensure community participation • Community mobilization • Strengthen Health committee • Quality, equitable service
Parliaments, Prime Minister's Office, Council of Ministers', Regional Governments	• Ratification policies, proclamations, etc • Resources allocation	• Implementation of policy, proclamations, etc • Equity & quality • Plans and Reports	• Organizational restructuring	High	• Put in place strong monitoring and evaluation system and comprehensive capacity building mechanisms
Line Ministries (Education, Finance, Water, Labor, Women's Affairs, Agriculture, etc)	• Intersectoral collaboration	• Evidence-based plan • Reports • Effective and efficient use of resources & coordination • Technical support	• Fragmentation • Dissatisfaction • Considering health as low priority	Medium	• Collaboration • Transparency • Advocacy
Development Partners	• Harmonization and alignment • Participation • Additional financing • Technical support	• Financial fiduciary • Accountable and transparent system • Involvement in planning, implementation & M&E	• Fragmentation • High transaction cost • Inefficiency and ineffectiveness	Medium	• Government leadership • Transparent procedures • Efficient resource utilization system • Build financial management capacity
CSOs, NGOs, Diaspora, Professionals' A.	• Harmonization & Al, • Participation, resource & TA	• Involvement in planning, implementation & M&E	• Dissatisfaction • Fragmentation	Medium	• Transparency, Advocacy • Capacity building
The private for profit	• Quality	• Partnership, Rules & regulations	• Low quality	Medium	• Transparency, Collaboration • Advocacy,
Civil servants	• Commitment, • Participation	• Conducive environment • Transparency	• Dissatisfaction • Low productivity • Attrition	Medium	• Motivation, Involvement

3.4. Strategy of the HSDP-IV

Within the government's overall vision for Ethiopia to become a middle-income country in a few years after the end MDG 2015, the health sector of Ethiopia has to set stretched objectives for the effective health interventions with the aim of reaching every section of population. One of the unique features of a sound health strategy will be the extent it sought linkages amongst the health system challenges and the proposed strategic solutions/interventions including resources and the level of results expected to be achieved. It includes defining customer value proposition, strategic themes, strategic results, and perspectives.

3.4.1. Customer Value Proposition of HSDP-IV

In the context of HSDP IV, customer value proposition is the attributes that define services that the health sector should provide, the principles underpinning its relationship with the community and how the health sector wishes to be perceived. This is a critical factor in developing, deepening and retaining the sector's relationship with the community towards the achievement of the mission.

Table 3: The Ethiopian Health Sector Customer Value Proposition

Product or Service Attributes	Image	Relationship
The products and services that the Ethiopian Health Sector provides have the following characteristics: • Accessibility–information, physical, financial, etc • Timeliness of services • Quality of health care services and information, • Safety and healthy environment • Empowering community and employees • Conducive environment	The image that Ethiopian Health Sector wants to portray has the following characteristics: • Transparent • Supportive • Trustworthy • Professional • Customer-Friendly/Oriented • Committed	The relationship that Ethiopian Health Sector wants to have with its community could be described as: • Complimentary • Cooperative(participatory) • Respectful & ethical • Harmonious(Mutual Understanding) • Transparent Relationship • Dependable (Stewardship) • Responsive • Equitable

3.4.2. Strategic Themes, Strategic Results and Priorities

Strategic Themes are the main focus areas of the sector‘s strategy forming the key areas in which the Health Sector must excel in order to achieve its mission, vision and strategy. Strategic Themes are the Sector’s "Pillars of Excellence." For each theme, an explicit Strategic Result, or a description of the desired outcome is articulated. Strategic themes of HSDP IV describe areas of focus where the health sector should excel in order to achieve its objectives and targets.

Strategic themes:

- Excellence in Health Service Delivery and quality of care
- Excellence in Leadership and Governance
- Excellence in Health Infrastructure and Resources

Strategic Theme 1: Excellence in Health Service Delivery

The provision and management of curative, preventive, rehabilitative and emergency health services, and the promotion of good health practices (personal hygiene, nutrition, environmental health) at individual, family and societal level. It includes provision of maternal, neonatal, child, youth and adolescent health services and public health emergency services.

Strategic Result 1: A community that practices and produces best health, protected from emergency health hazards and has access to quality health care at all levels and at all times

Key concepts:

- Health Promotion
- Disease prevention
- Curative and rehabilitative service
- Public Health Emergency Management
- Emergency Medical (system)service

- Health service delivery at household, community and facility level

These concepts are mainly to improve maternal, neonatal, child, adolescent and youth health, nutrition, hygiene and environmental health (WASH) and to reduce/combat HIV/AIDS, TB and Malaria and other communicable and non communicable diseases.

How will successes be measured?

- Increased Knowledge, Attitude and Practice of the community
- Reduction of maternal, neonatal and child morbidity and mortality
- Reduction in incidence and prevalence of communicable and non-communicable diseases
- Reduction of malnutrition, wasting and stunting
- Controlling and reduction of medical and epidemic emergency

How will these help to move to the higher level of success?

- Ensuring an effective and timely delivery of quality health care
- Ensuring quality and provision of services as per the standard,
- Accessibility of services (physical, financial, information and cultural)
- Enhancing behavioral change communication

Strategic Theme 2: Excellence in Leadership and Governance;

Planning, monitoring, evaluation, policy formulation and implementation that is evidence-based. It also includes the development and implementation of a regulatory framework. It incorporates the equitable and effective resource allocation and leadership development within the sector and the community.

Strategic Result 2: Communities served by accountable and transparent institutions and its safety ensured. Decision making in the sector is evidence-based and the promotion of equitable and effective allocation and/or application of health resources

Key concepts:

- Evidence based policy formulation and implementation.
- Planning, Monitoring & evaluation
- Ensuring equitable and effective resource allocation (finance, human capital and infrastructure)
- Leadership and community development
- Regulatory framework
- Accountability and transparency
- Harmonization and alignment

How will successes be measured?

- Use of research and health information outcomes for evidence-based decision making(including planning, policy formulation and developing regulatory frameworks)
- Improved partnerships
- Timely decision
- Empowerment of employees at every level
- Equitable resource allocation (finance, human capital and infrastructure) on evidence based need
- Enhancement in the public safety

How will these help to move to the higher level of success?

- Policy will define priorities
- Public Private partnership will be enhanced
- Enhanced community participation(planning, M &E, regulation enforcement, policy formulation) and ownership, satisfaction
- Efficient use of resources

Strategic Theme 3: Excellence in Health Infrastructure and Resources;

Development, rehabilitation and maintenance of health facilities and medical equipment that meet standards and are accessible to the community who should be served by qualified and motivated health professionals

Strategic Result 3: Ensuring communities have access to health facilities that are well equipped, supplied, maintained and ICT networked as per the standards and are well staffed with qualified and motivated employees.

Key Concepts:

- Expansion of new health facilities and other health infrastructure,
- Expansion, rehabilitation and maintenance of the existing health infrastructure.
- Pharmaceutical supply- planning, quantification, selection, procurement storage and distribution
- Health care financing- resource mobilization and risk pooling
- Health workforce – training, deployment, career development and improved HRH management
- Technology transfer – adoption of new technology and practices for the production and utilization of health care products.
- Effective medical equipment management
- Enhanced Information Communication Technology for health

How will successes be measured?

- The extent that communities are accessing standardized health facilities
- No stock outs of essential drugs at all health facilities
- Ensuring community's enrollment in health insurance schemes.
- Improvement in the functionality of medical equipment
- Enhanced retention for qualified work force
- Development of critical work force skills
- Improved access and quality of health services via use of ICT

How will these help to move to the higher level of success?

- Ensuring the community's access to standardized health facilities the services of which are delivered by qualified and motivated health professionals.
- Health facilities will have better communication and data exchange to improve the quality of reporting and service provision

3.4.3. Strategic Perspectives

Perspective	Key Concept	Key Questions
Community	"Empowerment" "Engagement" "Ownership"	How can we enable the Community to produce & own its health?
Financial	"Effectiveness"	How do we mobilize and utilize more resources effectively and efficiently?
Integration & Responsiveness (Internal Process)	"Quality"	How can we enhance our integration & responsiveness in order to improve quality, timeliness, & functionality?
Capacity building (Learning & Growth)	"Capacity"	To excel in our processes, what capacities must the health sector and the community has and should improve?

Table 4: Perspectives of HSDP IV

3.5. Strategic Objectives and Map for the Ethiopian Health Sector

Strategic Objective - C1: Improve Access to Health Services

This strategic objective is meant to improve accessibility of health services in order to ensure the utilization. Major areas addressed under this strategic objective are to improve health of mothers, neonates, children, adolescent and youth; improve nutrition status; improve hygiene and environmental health; reduce the incidences and prevalence of HIV/AIDS, TB, malaria and other

communicable and non-communicable diseases and hospital emergency services and referral system with emphasis to maternal and newborn care.

The expected outcome will be to increase the confidence of citizens in the health system so that they will proactively seek prevention, and treatment services from health facilities. They have to believe and develop confidences that they will be able to receive best medical care when they are in need, they are at low risk of contracting diseases ultimately leading to better health status.

In order to achieve the desired results, Health Extension Programme will serve as a primary vehicle for prevention, health promotion, behavioral change communication and basic curative care through effective implementation of the 16 packages. Health centers will serve as a first curative referral center for Health Posts and will provide health care that will not be available at the HPs through ambulatory and some cases of inpatient admissions. Health centers, primary hospitals and general hospitals will be the main hubs for the reduction of maternal mortality by providing BEmONC and CEmONC. Referral and specialized hospitals are meant for the handling of more complicated and sophisticated health care including for the care of non-communicable diseases.

PMTCT, TB case detection, attendance of delivery by skilled health workers, environmental management of malaria and non-communicable diseases will be given enhanced attention. Family planning programme will focus on ensuring contraceptive security and provision of long lasting and permanent contraception. Focused antenatal care with four visits per pregnancy will be mainstreamed at all service delivery levels. WASH will be integrated with other service delivery modalities and will be implemented at all levels of the health care system.

Strategic Objective – C2: Improve community ownership

This strategic objective embrace creating awareness and changing the behavior of the community in order to ensure their full participation in the policy formulation, planning, implementation, M&E; regulation of health services; and resource mobilization for the health sector.

The expected outcome of the strategic objective is community empowerment in order to ensure the continuity and sustainability of health programs through involvement in the administration and regulation of their respective local health facilities. HSDP IV aims to ensure community ownership and empowerment through effective social mobilization, enhanced and sustained awareness creation, and creating conducive environment and supporting community organizations. Communities will be represented on governance boards of all public health facilities. Moreover, local government councils and HEWs will play extensive role in the social mobilization, increasing community's awareness of their rights by creating enabling environment.

Community Health Promoters, who will be women recruited from graduated model households are responsible for the improvement of community ownership. Community Health Promoters are

volunteer health workers and will be engaged in the promotion and prevention activities at household and community level with the guidance of the HEWs.

Strategic Objective - F1: Maximize resource mobilization and utilization

This strategic objective includes a proactive approach in the mobilization of resources from domestic and international sources; enhance pool funding; collection and use of revenues by health institutions and establishing a risk pooling mechanisms. It also includes effective and efficient use of resources, sound financial management and performance based financing; equitable and evidence- based allocation of resources to priority interventions and programmes in the health sector.

The ultimate outcome of this strategic objective is making sure that adequate resources are mobilized and are made available for the financing of the health sector both from internal and external sources; equitable resource allocation, greater improvement in the resource absorptive capacity and decreased wastage of resources and finally ensure financial protection of the citizens.

The capacity of health administrations at all levels will be built to develop evidence based plans to enable health managers use evidences for active negotiation with administrative councils in order to increase government allocation to health. Technical support will be given to sub national levels to put in place the necessary requirement for facility based revenue generation and proper use, and implementation of exemption and waiver system. Facility governances will be strengthened to ensure accountability in the use of funds for improving access and quality of health services.

Technical and financial resources will be mobilized for proper piloting, evaluation and scaling up of CBHI. The necessary institutional framework will be setup and extensive promotional works will be conducted for rapid scaling up of SHI. Experience sharing and networking will be promoted among health facilities on the implementation of comprehensive HCF reforms. Government in collaboration with development partners will ensure financial protection for the poor by allocating funds, and for improving the effectiveness and transparency of the waiver and exemption systems. Dialogue between the government and development partners will be enhanced to improve aid effectiveness. Capacity of FMOH and sub national health administrations will be improved for mobilization of resource, management of aid, reduce fiduciary risks, account and to liquidate donor funds.

HSDP IV aims to achieve the outcome in this objective through the implementation of various strategies such as strengthening the existing linkages with MOFED, BOFED and WOFED; enhancing evidence based planning in order to accentuate the relevance of the planned resource allocation to the local needs; building human resource capacity in terms of numbers and skills for better programme implementation and resource absorption; simplification in the disbursement and accounting for funds; and the procurement procedures and systems.

Development partners will be urged to reduce the tying up of aid and the complexity of fund management in order to reduce transaction costs and improve budget absorption as agreed in the IHP+ Compact. The Integrated Financial Management Information System (IFMIS) will be designed, pilot tested and implemented at all levels of the health system in collaboration with MOFED, BOFED and WOFED. IFIMS will serve to enhance the use of funds for planned activities, provide timely and complete physical and financial reports on the use of funds to all stakeholders.

Result based financing will be pilot tested and implemented to increase motivation for resource use while ensuring value for money. In addition, a guideline which is currently under development will be finalized and will be implemented to enhance accountability in resource use, liquidation and accounting at all levels of the health system.

Strategic Objective - P1: Improve quality of health services

It includes provision of health services as per the standard by health facilities at all levels. This standard includes: speed of delivery, harmonization at service delivery point through the integration of vertical programmes in order to ensure that there will be holistic approach to service delivery and also avoid missed opportunities in the delivery of service, effectiveness of the services and patient safety, ethical and professionalism in service delivery, and availability of the required inputs (HR, finance, pharmaceuticals ...)

The expected outcome is the creation of a health system that satisfies the community's health care needs through the fulfillment of the required inputs, delivering safe and optimum quality of health services in an integrated and user-friendly manner.

Strategic Objective – P2: Improve Public Health Emergency Preparedness and Reponses

This strategic objective includes improvements in the health risk identification, early warning, response and recovery from existing and emerging disease epidemics, acute malnutrition, and natural disasters of national and international concern. The expected outcome of the strategic objective is early verification, rapid response and containment of public health emergencies.

The strategies that will be put in place include community involvement; resource mobilization; integrated communications and information systems across multiple sectors; multisectoral coordination for emergency preparedness and response; advanced operational readiness assessment; comprehensive training and evaluation to all involved; and application of proper ICT. These strategies will contribute towards an effective early warning, preparedness, response, recovery and rehabilitation system as it has been elaborated in the Public Health Emergency Core Process.

Strategic Objective – P3: Improve Pharmaceutical Supply and Services

This strategic objective is comprised of increasing the availability of pharmaceuticals (medical equipment and products for prevention, diagnosis and treatment) at an affordable price and in

useable conditions, uninterrupted and adequate supply to health facilities; significant reduction in the pharmaceutical wastages and improved rational drug use. Outcome of the strategic objective is adequate availability of the right pharmaceuticals at the right place and at the right time in the right condition and is used properly by patients and clients.

More resources will be mobilized to improve the per capita expenditure on drugs. Capacity building activities will be conducted for enhancing the effective management of Revolving Drug Fund (RDF) at all levels. Pharmaceuticals will be procured in bulk and will be delivered directly to service delivery points by PFSA. Pharmaceutical hubs and warehouses will be constructed and will be strategically located to improve proximity and efficiency in the distribution. Alternative strategies including outsourcing will be used to ensure cost effectiveness in the of transportation pharmaceuticals to service delivery points while maintaining the quality of products. LMIS will be developed in such a way that it will be integrated with HMIS and stock management of the health facilities in order to improve forecasting and quantification of pharmaceuticals. Regular operational research will be conducted with the aim improving the efficiency of the supply chain management on a continuous basis. Patients and health workers will be involved in the improvement of rational use of drugs.

Strategic Objective – P4: Improve regulatory system

This strategic objective is about ensuring safety in the delivery of health services, products and practices; prevention of professional malpractices; strengthening quarantine services; enhancing environmental health activities; enforcing regulations and prevention of drug abuse; regulation concerning institutional solid and liquid wastes disposal. Expected outcome includes community safety, healthy environment, compliance to the regulatory standards and increased community confidence in the health law and safe delivery of health services. Compliance to the regulations will ensure proper disposal of solid and liquid wastes by institutions.

HSDP IV aims to achieve the expected outcome through effective implementation of the Health and Health Related Regulatory Core Process. Through the design of the core process, comprehensive standards for all levels of health institutions along with standard operating procedures for premises, practices, products and personnel have been developed. Furthermore, the required system inputs for the implementation of the core process at all levels of the health system have been defined. As this is a new core process, extensive capacity building venture will be a critical undertaking under HSDP IV towards realizing effective regulation in the sector.

Implementation of this strategic objective applies: enhancing community involvement in health and health related services and products regulation; promoting health regulatory laws; issuing special permit for import, export, manufacturing, distribution, wholesale and storage of substances; undertaking demand reduction and supply management activities for substances that are prone to abuse; improving the efficiency of hygiene and environmental health control activities; post marketing surveillance; and comprehensive capacity building.

Strategic Objective – P5: Improve evidence based decision making: harmonization and alignment

This strategic objective is about evidence-based decision making through enhanced partnership, harmonization and alignment: and integrations of projects and programmes at the point of health service delivery. It includes identification of health system bottlenecks; research; HMIS; performance monitoring; quality improvement; surveillance; use of information for policy formulation, planning, and resource allocation. The expected outcome of the strategic objective is proper generation and use of evidence to address the critical health problems of the community at all levels of the health system and the realization of one-plan, one-budget and one-report and effective integration and alignment of health programmes and projects.

A mechanism will be put in place to prioritize researches to be based on public health importance. All researches in the health sector will conform to the Algiers Declaration in order to improve efficiency and effectiveness in the operationalization and use evidences from research. In order to improve financing for M&E, a minimum of 15% of vertical funds will be allocated to the scaling up of an integrated M&E. Further, resources will be leveraged for the scaling up of HMIS from partners that are implementing projects/programmes at facility levels. Commitment of the government will be secured through institutionalization and sustaining the M&E at facilities, and at the sub-national health administrations by increasing resource allocation. FMOH will provide a start up support to regions for scaling up of HMIS (tools, training, etc).

Use of information for decision making and quality improvement will be promoted and monitored by M&E units at all levels. Data from different sources will be triangulated to validate information and to enhance the level of accuracy. FMOH will institutionalize and support the dissemination of best practice to enhance the use of evidence for decision making. Technology will be implemented after pilot testing and in-depth evaluation for appropriateness and sustainability. FMOH will work very closely with Ministry of Education, universities and partners in accelerating pre-service trainings in HIT and epidemic intelligence officers. Evidence based woreda planning will be undertaken annually to improve the use of evidences for better decision making.

HSDP IV plans to achieve the “one” principles of harmonization & alignment by setting out various strategies at national and sub national levels. Improving a transparent, accountable and socially equitable use of donor funds coupled with government leadership to take forward the agenda of harmonization and alignment are strategies that will be deployed on the government side.

Development partners are expected to strategize their way of doing for ensuring the predictability of funding; delegation of decision making power to country offices; to make effective use of the government systems and processes for planning, implementation, monitoring

and evaluation. Both government and development partners will make every effort to achieve value for money by improving resource allocation to priority health interventions; will avoid creating gaps and overlaps in the financing; resort to conducting regular independent evaluation. Both will make commitment and adhere to the principles of harmonization and alignment and make use the lessons learnt from such processes for continuous improvement. Evidence based woreda planning will be done annually to improve evidence-based decision making, improvement in health programmes and health care delivery.

Strategic Objective – CB 1: Improve Health Infrastructure

This strategic objective consists: expanding, equipping, furnishing, maintaining and managing health and health related facilities, expanding use of relevant technologies including health information technology, and development of infrastructure for pharmaceutical supplies, and technology transfer and vaccine production.

The outcome of the strategic objective is to ensure that health and health related facilities are well built, maintained, equipped, furnished, use appropriate technologies and are located within a reasonable distance from the beneficiary population.

Capacity of the health sector will be built to conduct preventive maintenance, outsource and manage contracts. FMOH will be in charge of the Federal Hospitals, regions will be responsible for facilities accountable to RHBs. Zonal health departments will manage the building work, maintenance and equipment for facilities that are accountable to zonal health departments and woreda health offices will mange health facilities under their jurisdictions.

The cost of maintenance will be covered by the respective level of health administration and health facility. FMOH will mobilize resources to support sub national levels in equipping health facilities as per the standard. Health facilities are expected to cover the cost for some equipment and maintenances.

Strategic Objective – CB 2: Improve Human Capital and Leadership

This strategic objective entails: leadership development, human resource planning, development and management including recruitment, retention and performance management; community capacity development; and technical assistance management.

Outcome of the strategic objective is ensuring the adequate availability of skilled and motivated staffs that are committed to work and stay in a well managed sector.

HSDP IV will make use of a mix of strategies to achieve the above-mentioned outcomes such as ensuring demand driven production of human resources; maximum use of the available resources in producing key categories of health workers for which there is scarce supply; improving inter-sectoral collaboration in HRD; enhancing private sector involvement; enhancing quality assurance in the training of health professionals; utilization of appropriate ICT to enhance the

quality and efficiency of medical education; improve geographic distribution of HRH; strengthen regulatory system; enhance cost effectiveness in the retention and motivation schemes.

Health Sector Strategy Map:

A strategic map below illustrates the cause and effect relationship of strategic objectives in the health sector. The map provides an insight how the Health sector is planning to establish an added value to the community and how the outcome and the customer value proposition intended results are achieved.

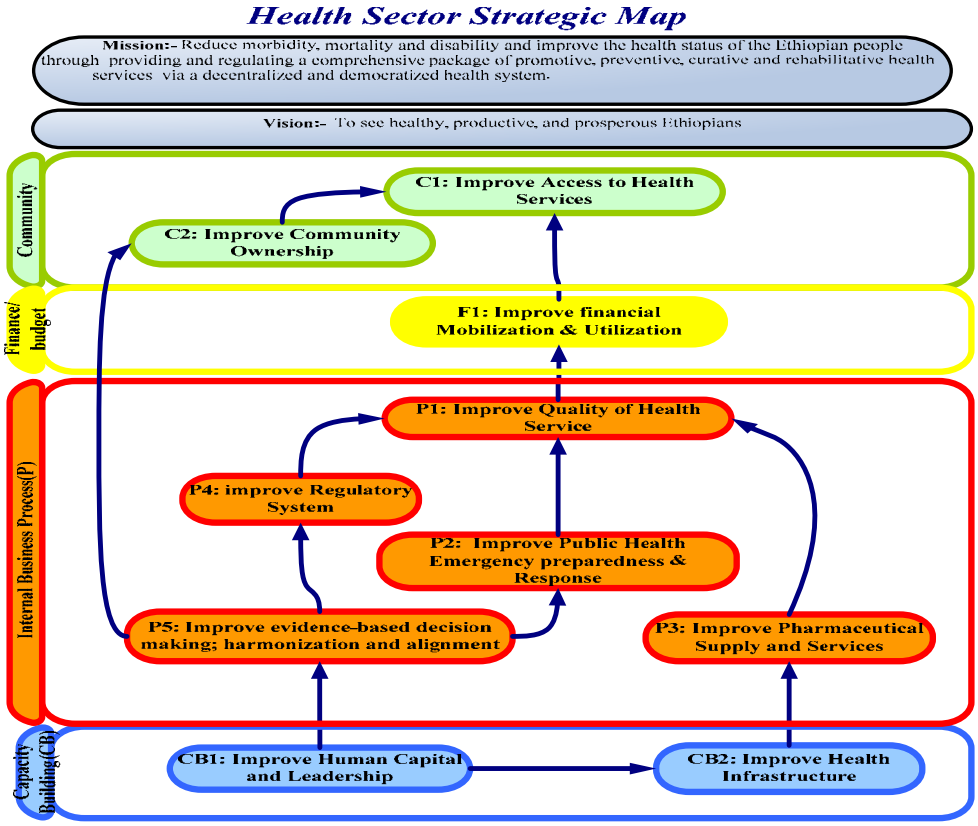


Figure 1 Health Sector Strategy Map

3.6. Performance Measures and Strategic Initiatives of HSDP IV

3.6.1. Sector Core Performance Indicators & Targets

Table 5: Summarized Priorities and Targets of HSDP IV

Priority Areas	Impact	Outcome	Vehicles	Bloodlines
Maternal and New born Health	MMR 267/100,000	CPR= 66% Deliveries attended by skilled birth attendants= 62%	Health Post 1:5,000 population	Health Extension Program Supply chain management
Child Health	U5MR 68/1000 IMR 31/1000	Fully Immunized= 90% Pneumonia treatment 81%	Health Center 1:25,000 population	Regulatory system Harmonization and Alignment
HIV/AIDS	HIV incidence 0.14	ART =484,966 PMTCT= 77%	Primary Hospital 1: 100,000 population	Health Care Financing Human Resource Development
TB	Mortality due to all forms of TB= 20/100,000	TB case detection 75%	General Hospital 1: 1,000,000 population	Health Information System
Malaria	Lab confirmed Malaria incidence <5 per 1000	LLIN=39 million IRS=77% of targeted households	Specialized Hospital 1: 5,000,000 population	Continuous quality improvement program
Nutrition	Wasting prevalence 3%			Referral system

3.6.2. Directions of HSDP IV

A number of initiatives and programmatic interventions were under implementations before HSDP IV. The majority of them will continue to be implemented as per the agreed strategic directions. This section, however, outlines new strategic directions or major refocuses that will attract more attention in selected areas.

3.6.2.1. Health Extension Programme

HSDP III has registered remarkable achievements in the scaling up of rural HEP coverage in terms of putting in place the necessary infrastructure i.e. HPs, equipment, HEWs and Health Extension Supervisors. Hence, HSDP IV will focus on the following aspects of HEP:

- Scaling up of Urban and Pastoralist HEP.
- Maintaining coverage and improving the quality of HEP in rural areas.

3.6.2.2. Quality of Health Care

Quality of Health Care is the degree to which health services for individuals and populations increase the likelihood of the desired health outcomes consistent with current professional

knowledge. The delivery of quality health services is central to improving the health status of the population. In addition, satisfying patients and clients is the primary goal of the Government's reform programme including BPR.

HSDP IV will focus on a comprehensive and continuous quality monitoring mechanism that will enable all levels of the health system (both management and service delivery) to look at all aspects of performance and quality of services. Inputs, processes and outcomes of the health care system will be monitored for quality, and the mechanism will also seek to involve all managers and every health care worker in the ongoing processes of quality improvement at all levels of the health system.

Improving the quality of services will be realized through scrupulous implementation of tools, manuals and standards that have been developed as part of BPR. BPR already defined quality structures, quality planning, quality performance measurement, quality improvement activities, and mechanisms for involving actors, evaluation of quality on programs, service delivery and health management at all levels of the health system. Although almost all of the core and support processes have a quality component in them; rigorous implementation of the Performance Monitoring and Quality Improvement Standard Operating Procedure, and the Health Regulatory Core Processes becomes indispensible to ensure adherence to standards by all actors in the sector. Health and Health Related Regulatory Core Process is designed to effectively monitor the adherence by all health service providers focusing on professional practice, quality of products and premises of service delivery. Regulation of health services will be enhanced by putting in place an independent inspection. This will imply the implementation of the Health Service Regulatory Core Process in order to properly regulate health services and take the necessary corrective measure. This will include regular monitoring of premises, personnel, practices and products to ensure adherence to agreed standards.

The Quality of Health service applies a three-pronged approach to improving quality of health services. These are supply side interventions, demand side interventions and regulatory aspect (stated above). The supply side interventions include availing adequate number of skilled and motivated professionals; strengthening the supply chain management system in order to ensure adequate and uninterrupted supply of pharmaceuticals at the point of service delivery. It also include improving the fiscal space of health institutions through the implementation of HCF reforms to ensure the allocation of adequate resources for the procurement of commodities, maintenance of infrastructure, creating conducive environment for patients and clients as well as motivation of health human resources. An inbuilt quality assurance mechanism will be put in place through effective implementation of the Performance Monitoring and Quality Improvement Standards and Tools at all levels of the health system.

Demand side interventions include active participation of the community. Community participation is an important aspect of improving quality of services as it guarantees that patients' and clients' opinions are heard and their satisfaction with services is optimized. Community members will therefore be included in health facility governance boards, a patients' rights charter will be developed and regular surveys on client satisfaction will be conducted. Involving the community in the planning, implementation, monitoring and evaluation of health interventions will be enhanced. The quality of care in the curative and rehabilitative services will be addressed at each level of service delivery point and all facilities will be organizing their service delivery into impatient services, outpatient services and emergency medical care. All patients will pass through screening/triage for prioritization. In the case of emergency case, a patient will be

referred directly to the emergency medical care and will be able to receive an immediate attention and treatment.

3.6.2.3. Scaling up of Civil service Reform

As part of the ongoing Civil Service Reform, eight Core Processes and five support processes have been designed with BPR and implementation, which has started since HSDP III. However, the pace and quality of implementation has not been moving as expected due to various factors. HSDP IV will therefore focus on the following aspects of the BPR.

- Enhancing the commitment of leadership at all levels of the system.
- Building implementation capacity.
- Continuous improvement of the BPR processes.
- Scaling up of best practices.

3.6.2.4. Special attention to critical programmes

Despite ambitious targets, the performance of HSDP regarding to some programmatic interventions remained unsatisfactory. Some of these include skilled attendance on delivery, PMTCT and TB case detection rate. Hence, HSDP IV will provide significant attention to these programmes in terms of political commitment, better allocation of resources and close follow up.

3.6.2.4.1. Human Resources Development

HSDP IV will accord due attention to:

- Reinforcing and institutionalization of HRH legal frameworks in the context of the overall health policy and in line with the decentralized health system of the country
- Achieve the balance towards production of the right number and skill mix of health workers
- Improving the availability of key HRH categories at all levels through scaling-up the training of professionals with scarce supply such as medical doctors, IESO and midwives
- Develop and institutionalize human resource management systems at all levels of the decentralized health system
- Improving the motivation and retention of health human resources through implementation of evidence based financial and non-financial incentives
- Ensuring that in-service training are standardized and support the health and management workforce career progression and skill development

3.6.2.4.2. Health Infrastructure (Construction and ICT)

The construction of additional facilities had been a major focus of HSDP III. HSDP IV will introduce a shift in focus as follows.

- Expansion and conversion of selected HCs to primary hospitals in order to enable them provide emergency surgical services focusing on Comprehensive Emergency Obstetric Care.

- Preventive maintenance and rehabilitation of health facilities (HPs, HCs, and hospitals).
- Completion in the construction of the 16 blood banks thus fulfilling the necessary facilities and as a significant contribution towards achieving MDG5 through improving the availability of adequate and safe blood.
- Priority to the construction of logistic hubs to ensure effective storage and distribution of pharmaceuticals.

Ethiopia is among the top-ranking countries in terms of investment in ICT infrastructure. Hence, HSDP IV will focus on making best use of this opportunity to improve access and quality of care. The use of ICT for health will focus on three main areas:

Tele education will be implemented to support hospitals and the newly established universities that will be engaged in accelerated training of health professionals. Tele-education is expected to fill the gap in capacity to handle accelerated training of health professionals.

Tele-medicine will be scaled up to more universities and hospitals based on the lessons learnt from Jimma network (Jimma University, Nekmte, Metu, and Woliso Hospitals). This will enable patents to get specialized service in areas where there is scarcity of specialists.

e-HMIS is the other crucial area of focus for ICT application. Application of appropriate ICT at HEP level and electronic health information transfer will be the areas of focus. EMR will be scaled up to referral hospitals based on the lessons learnt from Dill Chorra Hospital.

3.6.2.5. Special Support to Emerging Regions

The four Emerging Regions, namely Afar, Somali, Benshangul Gumuz and Gambella present a unique challenge in terms of health service delivery and health system development. These regions are characterized by poor infrastructure, hardship environmental conditions, and pastoral or semi pastoral population. HSDP I, II and III have emphasized the need for tailored approach and support to these regions in order to bring them to equal footing with the rest of the regions.

Accordingly, HSDP IV will continue and further strengthen the special support provided to these regions through various mechanisms already put in place. These include participation in the multi-sectoral planning under the coordination of the Ministry of Federal Affairs; providing special support in for the health planning, budgeting, implementation, monitoring and evaluation of health programmes; provide need based capacity building in order to ensure sustainability; develop and implement a contextualized health service standard including pastoralist HEP, HC to population ratio, staffing pattern and hardship allowances. The Pastoralist Health Promotion and disease Prevention Directorate in the FMOH is given the responsibility for coordinating the special support to the Emerging Regions.

3.6.2.6. Climate Changes and Health:

Globally, the issue of global warming or climate change has emerged as a major scientific, developmental and political issue in the past two decades. It is a global phenomenon the impacts of which will affect all countries, but more so the poorer and vulnerable countries of Africa that are least responsible for it. In this respect, the Federal Democratic Government of Ethiopia has been officially attending different international technical, scientific, political, and Intergovernmental Panel meetings on Climate Change (IPCC). Ethiopia is the signatory for the ratification of the United Nations Framework Convention on Climate Change (UNFCCC) and

the Kyoto Protocol. It also fully supports initiatives by the African Partnership Forum in 2007, the WHA resolution 2008 & others. As part of the efforts to implement the conventions, numerous activities are being undertaken by MOFED & the National Metrologic Services Agency including other sectors.

Climate change could jeopardize achievements of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the health sector to improve public health and reduce health inequalities. Some of the effects of climate change are related to more variable weather, heat waves, heavy precipitation events, flooding, droughts, and more intense storms such as hurricanes, sea level rise, and air pollution. Each of these changes has the potential to negatively affect health. The likely direct and indirect health effects of increased temperatures and extreme weather conditions such as acute heat stress that could be followed by exhaustion and heat stroke; trauma; air quality/pollution, vector-borne and zoonotic diseases, water- and food-borne diseases and mental health and others. It is worth noting that while climate change is recognized as a global issue, its effects will vary across geographic regions and populations.

To this effect, The FMOH will raise community awareness, initiate trainings to health professionals and researchers on the health effects of climate change, ensure that systems are in place to detect and track climate change induced health problems, make the necessary preparations to respond to, and manage climate change associated risks. The FMOH will be engaged in such activities in collaboration with the Environmental Protection Authority..

3.6.2.7. Gender Mainstreaming

Gender mainstreaming perspective is one of the government focus areas which should be addressed in all planning process. It reflects the process of assessing the implications of planning and actions on women and men in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of the Health Sector programmes; in all political, economic and societal spheres so that women and men participate and benefit equally from all aspects of development. These dimensions should be mainly addressed through: I) promoting gender equality & the empowerment of women, ii) enhancing equal opportunities in the participation of economic and social development including health iii) Increasing the utilization of health services by Women. The ultimate goal of gender mainstreaming in all sectoral planning and concerted actions are to achieve gender equality.

Emphasis of HSDP IV

Increase skilled attendance of delivery through:

- Accelerated training of midwives and emergency surgeons.
- Equip HC with BEmONC
- Equip all Hospitals including Primary Hospital to provide CEOC.
- Improve availability of safe blood and pharmaceutical supplies.
- Improving referral system.

PMTCT will be enhanced through:

- Integration with MNCH
- Link with HEP.
- Community mobilization.
- Improving ANC and institutional delivery coverage
- Routine HIV testing during ANC.
- Improving service accessibility.
- Public private partnership.
- Ensuring male involvement.

3.6.3. Performance Indicators, Targets & Strategic Initiatives

Strategic objectives are used to break strategic themes into more actionable activities that lead to strategic results. Strategic initiatives are long term or short term projects or programmes that should be implemented to ensure success of the strategy. They are selected in terms of their potential to bring significant impact in the sector's strategy.

Sector core performance indicators and targets are listed in table 5 under 3.6.1. Next are the performance indicators, targets and initiative by each strategic objective for the next five years of HSDP IV.

Strategic Objective C 1: Improve Access to Health Services

S.O.C.1.1: Maternal, neonatal, child and adolescent health

Targets:

1. Decrease maternal mortality ratio from 590 per 100,000 live births to 267/100,000
2. Decrease institutional maternal mortality rate to less than one.
3. Increase family planning service (CPR) from 32% to 66%
4. Decrease unmet need for Family Planning from 34% to10%
5. Reduce teenage pregnancy from 17% to 5%
6. Increase Focused ANC 1+ from 68% to 90% and ANC 4+ from 31% to 86%
7. Increase Deliveries attended by skilled birth attendants from 18.4% to 62%
8. Increase postnatal care coverage from 34% to 78%.
9. Increase proportion of deliveries of HIV+ women that receive full course of ARV prophylaxis from 8% to 77%
10. Decrease under five mortality rate from 101 to 68 per 1000 live births
11. Decrease infant mortality rate from 77 per1000 live births to 31/1,000
12. Increase Protection at Birth (PAB) against Neonatal tetanus from 42% to 86%
13. Increase Pentavalent 3, Measles, Full immunization, Rotavirus and Pneumococcal immunization coverage from 82%, 76.6%, 65.6%, 0%, and 0%, to 96%, 90%, 90%, 96% and 96% respectively.
14. Increase proportion of asphyxiated newborns who are resuscitated and newborns with neonatal sepsis who received treatment from 7% to 75%, from 22% to 74%, respectively.
15. Roll out community case management for common childhood illnesses in all health posts and increase proportion of health centers and hospitals that implement IMNCI to 100% from 52% and 62% respectively.
16. Increase adolescent and youth friendly reproductive health services in 100% of hospitals and health centers.

Comment [U1]: 25%

Initiatives:

1. **Strengthen and expand community and facility based maternal, newborn, child and adolescent health services.**
   - 1.1. Scale up family planning programme (community based FP services, social marketing, facility based and outreach long acting and permanent FP service provision)
   - 1.2. Scale up of midwife training.
   - 1.3. Scale up BEmONC, CEmONC.
   - 1.4. Conduct maternal death Auditing
   - 1.5. Service Integration with emphasis on RH-HIV integration, (in particular FP-HIV prevention linkages through common messages and dual protection) and harmonized approach among all partners.

1.6. Referral system including pediatric referral system.

1.7. Routine immunization and wild polio eradication.

1.8. Expand community and facility IMNCI.

1.9. Enhanced Youth Friendly services.

1.10. Capacity building on program management for maternal and child health services.

1.11. Health Extension Programme

1.12. Special, locally relevant and effective maternal and child health intervention to pastoralist areas

S.O.C.1.2: Nutrition

Targets

1. Decrease wasting prevalence among children under 5 from 11% to 3%; and stunting prevalence from 46% to 37%
2. Increase the proportion of newborns breastfed within one hour of birth from 69% to 92%
3. Increase the proportion of exclusive breast feeding of 0-6 months from 49% to 70 %
4. Increase the proportion of infants of 6 -9 months introduced to complementary food & continuation of breastfeeding from 54% to 65%
5. Increase the proportion of under 5 children managed for severe malnutrition from 23% to 91%.
6. Achieving cure rate > 75%, defaulter rate < 15% and mortality rate < 5% in TFP (both Inpatient care and OTP).
7. Increase the proportion of children in the age group of 6-59 months given vitamin A supplements every 6 months from 94% to 96%
8. Increase the proportion Children 2-5 years receiving deworming every 6 months from 86% to 96 %
9. Reduce the prevalence of anemia in women of childbearing age (15-49) from 27% to 12%
10. Increase the proportion pregnant women supplemented with Iron during their pregnancy from 10% to 86%
11. Increase the proportion of households using iodized salt from 4% to 95%

Initiatives

1. Sustaining the Enhanced Outreach Strategy, (EOS) with Targeted Supplementary Food, (TSF) and Transitioning of EOS into HEP
2. Health Facility Nutrition Services
3. Community Based Nutrition (CBN).
4. Micronutrient Interventions
5. Essential Nutrition Actions/Integrated Infant and Young Feeding counseling services

6. Institutional Strengthening for nutrition policy and program implementation and monitoring.
7. Health Extension Programme

S.O.C.1.3: Hygiene and Environmental Health

Targets:

1. Increase the proportion of Households utilizing latrine from 20% to 82%
2. Increase the proportion of villages (kebelles) free of open defecation from15% to 80%
3. Increase the proportion of households using household water treatment and safe storage practices from 7% to 77%

Initiatives:

1. Proper and safe excreta disposal system
2. Proper and safe solid and liquid waste management
3. Water supply safety measures
4. Food and hygiene safety measures
5. Healthy home environment
6. Arthropods and rodent control
7. Personal hygiene
8. Community Led Total Sanitation
9. Health Extension Programme

S.O.C.1.4: Prevention and Control of Major communicable Diseases

Reduce Incidence and Prevalence of HIV/AIDS

Targets:

1. Reduce incidence of HIV in adults from 0.28% to 0.14%
2. Increase Proportion of population aged 15-49 years with comprehensive knowledge of HIV/AIDS from 22.6% to 80%
3. Provide HCT (VCT+PITC) to 9.2 million people (annually)
4. Increase the proportion of young people aged 15-24 using condom consistently with non-regular partners from 59% to 95%
5. Increase the proportion of eligible children who are receiving ART to 95%
6. Increase the proportion of eligible pregnant women are receiving ART to 95%
7. Increase proportion of eligible Adults who are receiving ART from 53% to 95%
8. Increase the number of patients ever started on ART from 246,347 to 484,966
9. Increase the number of STI cases treated from 39267 to 60,000.

Initiatives

1. Strengthen enabling environment (capacity building, community empowerment, leadership and governance, mainstreaming, coordination and partnership)
2. Strengthen HIV prevention which includes:
   2.1. Intensifying the implementation of HIV/AIDS programmes (community conversation, school based and out of school interventions, addressing most at risk population, strengthened prevention with HIV positives and in development schemes and corridors)
   2.2. Reduce vulnerability of HIV infection among vulnerable and risk groups (through addressing gender inequality, income generation, girls education, fight against harmful traditional practices, stigma and discrimination, and integration of safety net programs with HIV/AIDS)
   2.3. Increasing access and utilization of services (HCT, STI, Condoms, Universal precaution and blood safety, circumcision and post exposure)
3. Create access and quality of chronic care and treatment (through enhancing service integration, laboratory, referral, availability of essential commodities OI, ARV drugs and reagents, Strengthen public private partnership and addressing human resource issue) .
4. Strengthen care and support to mitigate the impact of AIDS
   4.1. Strengthening the involvement of local communities in the care and support of HIV/AIDs
   4.2. Enhancement on the provision of standardized care and support to OVC &PLHIV
   4.3. Strengthening income generation activities to sustain the program
5. Health Extension Programme

Reduce Incidence and prevalence of TB and Leprosy

Targets:

1. Reduce Mortality due to all forms of TB from 64/100,000 to 20/100,000
2. Increase TB Case Detection Rate from 34% to 75%
3. Increase TB treatment Success rate from 84% to 90%
4. Increase Tuberculosis Cure Rate from 67% to 85%
5. Increase the proportion of MDR TB cases treated with second line drugs from 2% to 55%
6. Increase the proportion of PLHIVs screened for TB from 15% to 80%
7. Reduce proportion of registered TB patients who are HIV positive 24% to 10%

Initiatives

Emphasis of HSDP IV

TB Case detection will be enhanced through:

- Effective use of HEP as a vehicle to detect new cases, contact tracing and treatment follow up.
- Strengthened laboratory network.
- Improving information systems, including notification and referral routines.
- Correct estimation and regular updating of the TB burden.

1. Expansion of Community DOTS through maximum use of HEP
2. Strengthen case detection and management:
    2.1. Ensure early case detection, and diagnosis through quality-assured bacteriological diagnosis.
    2.2. Provide standardized treatment with supervision, and patient support.
    2.3. Ensure effective drug supply and management.
3. Addressing TB/HIV, MDR-TB and Leprosy;
    3.1. Scale-up collaborative TB/HIV activities.
    3.2. Scale-up the prevention and management of multidrug-resistant TB (MDR-TB).
    3.3. Address the needs of TB contacts, and of poor and vulnerable populations.
    3.4. Strengthen early detection of leprosy at community and facility level
4. Engaging all care providers,
    4.1. Involve all public, voluntary, corporate and private health care providers.
    4.2. Promote the use of the International Standards for Tuberculosis Care (ISTC).
5. Enabling and promoting research.
    5.1. Implementation of operational research on the effectiveness of DOTS expansion and TB/HIV collaborative strategies
6. Health Extension Programme

Reduce Incidence and prevalence of Malaria

Targets:

1. Reduce lab confirmed (RDT/Microscopy) malaria case fatality ratio among children less than 5 years old and adults to less than 2%
2. Reduce lab confirmed (RDT/Microscopy) malaria incidence per year, among children less than 5 years old and adults to less than 5 per 1000 population per year
3. 100% of suspected malaria cases are diagnosed using RDTs and or microscopy within 24 hours of the onset of fever.
4. Increase the proportion of households in malarious areas who own at least one LLIN from 65.6% to 90%.
5. Increase the proportion of pregnant women who slept under LLIN the previous night from 42.5% to 86%.
6. Increase the proportion of U5 children who slept under LLIN the previous night from 41.2% to 86%.
7. Increase the proportion of households in IRS targeted areas that were sprayed in the last 12 months from 55% to 77%.

8. No monthly malaria cases report for 24 months from previously malarious kebele's of targeted woreda's for elimination of malaria.

Initiatives

1. Early diagnosis and treatment of cases
   1.1. Improve the capacity of health workers in the diagnosis and case management of Malaria at health post level according to the national Guideline.
   1.2. Improve the capacity of health workers in the management and diagnosis of severe malaria at health centre and hospital levels according to national guidelines.
   1.3. Ensure the availability of essential commodities for the diagnosis and treatment of malaria
2. Selective vector control (LLIN, IRS, Environmental management)
   2.1. Geographical targeting and flexible distribution strategies for LLIN
   2.2. Procurement, distribution and storage of insecticide and spray materials and implementation of IRS through Health Extension Program as well as ensure public acceptance, practice, and participation in the IRS programs
   2.3. Environmental compliance
3. Health Extension Programme

Reduce Incidence and prevalence of other communicable Disease

Targets

1. Decrease the prevalence of leishmaniasis from 9.7% to 7% in males and from 4.5% to 2% in females.
2. Decrease prevalence of lymphatic filariasis from 23.7% to 16% in males and from 18.5% to 11% in females.

Initiatives

1. Complete mapping in the distribution of all NTDs (leishmaniasis, L.filariasis, schistosomiasis, soil transmitted helminthiasis**).**
2. Integrated approach and co-implementation of intervention packages
   2.1. Develop programme management and coordination guideline for NTDs.
   2.2. Design and develop nationally appropriate guideline prevention, early detection, diagnosis and registry for cancers.
   2.3. Advocacy, Social Mobilization and Sensitization for NTDs programme implementation
   2.4. Develop and sustain partnership and collaboration for integrated NTDs control
   2.5. Enhance integrated supportive supervision, research, monitoring and evaluation of NTDs programmes.

S.O.C.1.5: Prevention and Control of Non Communicable Diseases

Targets:

1. Increase cataract surgical rate (CSR) from 460 to 1,000 per 1,000,000 per year
2. Decrease the national prevalence of blindness from 1.6% to 1%.
3. Halt the speed of increment of the Prevalence of high blood pressure among adults at 31% in urban and 10% in rural
4. Halt the speed of increment of the prevalence of type 2 diabetes mellitus halted at 1-3%
5. Increase the proportion of health facilities providing integrated mental health services from 10% to 50%

Initiatives

1. Integrated approach and co-implementation of intervention packages
   - 1.1. Develop programme management and coordination guideline for NCDs.
   - 1.2. Design and develop nationally appropriate guideline prevention, early detection, diagnosis and registry for cancers.
   - 1.3. Advocacy, Social Mobilization and Sensitization for NCDs programme implementation with emphasis on major risk factors (Alcohol, smoking, diet and exercise) using the existing health extension programDevelop and sustain partnership and collaboration for integrated NCDs control
   - 1.4. Enhance integrated supportive supervision, research, monitoring and evaluation of NCDs programmes.
   - 1.5. Mental health service integration into all routine health service delivery system
2. Strengthen routine and outreach cataract surgery with emphasis to reaching inaccessible areas

Strategic Objective C2: Improve community ownership

Targets

1. Increase the proportion of model household graduated by HEP from 25.6% to 85%
2. Increase proportion health facilities with boards where communities are represented to 100%.
3. Increase the proportion of Community Health Promoters in relation to need (2 for every 50 Households) from 42% to 88%.

Initiatives

1. Strengthening Health Extension Program
2. Community empowerment/conversation and social Mobilization program **(**with emphasis of HIV/AIDS, Malaria, TB, Maternal and child, Nutrition and Environmental health)
3. Pursue communication and social mobilization to be gender sensitive, empower women and advocate for women led kebele health committee/Health promoters

4. Strengthen governance and leadership of public health facilities
5. Information Education and Communication – Behavioral Change Communication
6. Regulatory information delivery

Strategic Objective F 1: Improve Resource Mobilization and Utilization

Targets

1. Increase the per capita public expenditure on health from 16.1 USD to 32.2 USD.
2. Increase the share of health budget as a proportion of total budget from 5.6% to 15%
3. Increase the proportion of Public health facilities retaining and using their revenue from 20% to 100%
4. Increase the proportion of people enrolled in Health Insurance from 1% to 50%
5. Increase the ratio of health budget utilization to allocation to 90%

Initiatives

1. Establish Community based and Social Health Insurance.
2. Strengthen Facility Revenue Retention and utilization.
3. Enhance waiver and exemption system
4. Proactive resource mobilization
5. Establish private wings in public hospitals
6. Establish Integrated Financial Management Information System
7. Financial accountability and management program
8. Result Based Financing Schemes.
9. Strengthen resource mapping

Strategic Objective P1: Improve quality of health services

Targets

1. Increase customer satisfaction index from 50% to 100%
2. Increase Bed Occupancy Rate from 50.8% to 85%
3. Decrease Average Length of Stay from 6.7 days to 5 days.
4. Increase the proportion of referred patients completing referral process successfully (from the beginning to the feedback) to 80%.
5. Increase the proportion of emergency patient receiving emergency care in less than 5 minutes from 50% to 100%.
6. Increase Outpatient Attendance per capita from 0.2 to 0.7

Initiatives

1. Strengthen emergency management system.

2. Implement Quality management such as Nursing standard, laboratory standard, Infection Prevention, Medical record standard. Etc.
3. Provision of safe and adequate blood for transfusion
4. Establishing a well functional referral system
5. Regulatory service to both public and private sector institutions
6. Performance monitoring and quality standard operational procedures process
7. Integrate related health programs at management and service delivery levels

Strategic Objective P 2: Improve Public Health Emergency Preparedness and Reponses

Targets

1. Increases the proportion of epidemics averted to 75%.
2. Improve the proportion of epidemics controlled with zero mortality to 50%.

Initiatives

1. Active Surveillance and Epidemic Control
2. Vulnerability assessment and risk analysis;
3. Capacity building – (intelligence officers. national stockpile system etc)
4. Response & recovery operations (including emergency nutrition response)

Strategic Objective P 3: Pharmaceutical Supply and Services

Targets

1. Decrease procurement lead time (average time between order & delivery from supplier) from 240 days to 120 days
2. Decrease the proportion of health facilities with stock-out for essential drugs from 35% to 0%.
3. Increase the proportion of patients with adequate information on dispensed drugs from 68% to 100%.
4. Reduce the percentage of stock wasted due to expiry from 8.24% to 2%.
5. Decrease the percentage of prescriptions containing antibiotics from 58% to 25%
6. Increase the percentage of dispensed drugs adequately labeled from 43% to 90%

Initiatives

1. Quantification/forecasting and procurement system
2. Pharmaceutical storage and inventory control system
3. Pharmaceutical hubs and transport system.
4. Revolving drug fund management system
5. Integrated Pharmaceuticals Fund & Supply Management Information System (IPFSMIS)

6. Strengthen rational drug use.

Strategic Objective P 4: Improve regulatory system

Targets

1. Increases the proportion of health institutions complying with service standard to 100%
2. Increases the proportion of licensed/certified health institutions, food establishments, to 100%, respectively
3. Increase the proportion of registered and licensed traditional medicine to80%.
4. Increase Quarantine coverage to100%
5. Increase the proportion of registered and licensed professionals (Modern, alternative and traditional) to 100%

Initiatives

1. Inspection and licensing
2. Product quality assessment and registration
3. Strengthen Quality Quarantine service
4. Medico legal service

Strategic Objective P 5: Improve evidence based decision making through enhanced harmonization and alignment

Targets

1. Reach 100% in facilities and by programme managers using HMIS data for decision-making.
2. Increase the timeliness and completeness of HMIS reports from 57% to 90%.
3. Improve the correspondence between data reported and recorded from 15% to 90%.
4. Maintain the proportion of woredas with evidence-based plan aligned vertically and horizontally at 100%
5. Increases the proportion of Partners implementing “one-plan” to 100%
6. Increases the proportion of Health Development Partners providing funds through MDG PF to 75%
7. Increase the proportion of Partners using one report/HMIS to 100%.
8. Reaching that 95% of researches are conducted to address priority public health problems

Initiatives

1. Advocacy on Harmonization and Alignment
2. Regular Short and medium term resource mapping
3. Regular evaluation of adherence to the principles of harmonization and alignment

4. Integrate related health programs at management and service delivery levels
5. Institutionalize Monitoring and Evaluation of health programs
6. Conduct Research for program improvement
7. Strengthen district heath management system to institutionalize evidence based planning
8. Strengthen the generation and use of strategic information within the context of health system strengthening.
9. Evidence based problem solving comprehensive support to Pastoralist areas.
10. Respond to the health impacts of climate change through tracking of up to date information.

Strategic Objective CB 1: Improve Health Infrastructure

Targets

1. Maintain Health Post to population ratio at 1:5,000
2. Maintain Health Center to population ratio at 1:25,000
3. Increase Primary Hospital to population ratio to 1:100,000
4. Increase General Hospital to population ratio to 1: 1,000,000 population
5. Increase Specialized Hospital to population ratio to 1: 5,000,000 population
6. 100% of health facilities fully equipped and furnished as per the standard
7. 10 new Vaccines adopted and used Implement EMR in all Health centers and Hospitals
8. Implement e-HMIS in all woredas

Initiatives

1. Health Facility Construction program
2. Health Facility rehabilitation and upgrade projects
3. Health Facility Maintenance program
4. Cold Chain management and medical equipment maintenance
5. EMR, e-HMIS, networking, telemedicine and tele-education programmes.
6. Technology transfer & dissemination
7. Technical and financial support for Pastoralist area focused health facility expansion

Strategic Objective CB 2: Improve Human Capital and Leadership

Targets

1. Health Workforce Density: from 0.7 per 1,000 to 1.7 per 1,000
2. Physician to Population Ratio: from 1:37,996 to 1:5,500
3. Proportion of PHCU staffed as per standard in all geographic areas will increase to 100%
4. Proportion of PHCU that use Workload based staffing standard will increase to 100%
5. Implementation of e-HRIS at regional level will increase to 100%

6. Proportion of HRH departments at various levels that have at least one professional trained on HRM will increase to 100%
7. Competency level for essential knowledge and skill (disaggregated by category) will increase to 100%
8. 80% of the identified gaps filled by TA.

Initiatives

1. Scale up Training and development in line with staffing requirement detailed in the annex with focus on medical doctors, IESO, anesthesia professionals, midwives and HIT. Major initiatives with this regard include
    a. Establish/expand innovative, technology assisted medical and health science training program
    b. Transforming selected hospitals with potential into medical and health science training college
    c. Team based training of midwives, anesthesia professionals and IESO to address the BEONC and CEONC at PHCU level
    d. Enhance the availability of HIT through generic and work integrated training programs
    e. Effective coordination mechanism of service sector (employer) with education sector and training centers
2. Effective and targeted staff retention mechanisms developed and implemented
3. Development, scale up and implementation follow up of web based HRIS
4. Establish an HRH leadership and management development centre and relevant training programs and operational research
5. Regular review of HRH plan in view of unforeseeable changes as well as wider political and economic changes
6. Establish Continuous Professional Development Program (CPD)
7. Regular update of curricula for competence-based programs in pre-service education
8. Implement the agreed TA guideline

4. Costing & Financing of HSDP-IV

The Government of Ethiopia and its development partners have made considerable progress towards achieving MDGs. The health sector of Ethiopia has introduced and is vigorously pursuing the implementation of evidence-based high-impact intervention packages at all levels of the health care system. These include –HEP packages at the family and community level, and expansion of outreach services and medium to high level clinical care which are proven to potentially impact on the population by improving the coverage for health care. However, there still remain major bottlenecks which need to be tackled in the next five years of HSDP IV implementation. Evidences so far strongly point out that the primary obstacles against fast and sustainable targeted health gains through implementation of the proven high impact interventions are lack of resources and weak implementation capacity. There is also low level utilization of existing proven effective interventions by the community which would require working more on community education and mobilization aimed at substantially increasing the demand and the timely utilization of the available health care services at each level of the health care system.

In the previous health sector strategic plan implementation period, the Total Health Expenditure (THE)[3] more than doubled between 2004/05 and 2007/08, as documented in the fourth round of National Health Accounts (NHA). The nominal total health sector spending increased from Birr 4.5 billion (US$522 million) in 2004/05 to more than Birr 11.12 billion (US$1.2 billion) in 2007/08. Per capita THE also grew from US$7.1 per capita per annum in 2004/05 to US$16.1 in 2007/08[4]. Therefore, to attain the MDGs in the coming five year period, the health expenditure need to be increased and the HSDP IV costing is prepared taking this into consideration.

Comment [U2]: ????????

2.4. Costing Methodology

The costing exercise considers the Government's commitment to reach MDGs. Costing of HSDP IV is conducted using the Marginal Budgeting for Bottlenecks (MBB) tool, which is an evidence based result oriented planning and budgeting tool that utilizes knowledge about the impact of existing interventions on health in a country. MBB is a powerful analytical tool that aims to set interventions and their targets by assessing the health sector impediments to faster progress, identifying ways of removing them, and estimating both the costs of removing them and the likely effects of their removal on MDG outcomes & impacts such as child and maternal mortality. The MBB focuses on marginal cost and impact in mortality reduction that makes it a helpful tool to estimate the extra efforts and resources needed to reach the MDGs.

[3] THE captures health spending from all sources: government, donors, and private including household out-of-pocket payments.

[4] Federal Ministry of Health, 2009. The fourth round of Ethiopia's National Health Accounts (NHA).

MBB includes a generic list of health interventions[5] that have a high impact on child mortality or maternal mortality. Based on this generic list of interventions, country-specific interventions were selected in the country's intervention packages. A bottleneck analysis has been undertaken using the six coverage determinants of the representative tracer interventions out of the twelve sub-packages, focusing on those which can be delivered via the three service delivery modes: family/community based, population-oriented that are schedulable and individual clinical care. The bottleneck analysis also helps in the identification of system-wide supply and demand side bottlenecks and obstacles that would potentially impede the progress towards achieving adequate and effective coverage in the application of high-impact intervention packages in each of the main service delivery modes. Adequate coverage in this sense includes such factors as the availability of essential drugs and supplies, access to health services and health workers, first time and continued use of health-care services. Subsequent examination of the underlying causes of bottlenecks and the development of promising strategies for overcoming them allows the setting of "frontiers". The bottleneck analysis is conducted as part of the SWOT and Stakeholder analysis to set national coverage targets for interventions to be reached by 2014/15 the summary of the bottleneck is annexed.

2.5. Costing Scenarios & Assumption for HSDP IV

Ethiopia has made significant progress in expanding health services and improving health outcomes over the years through HSDP. However, despite considerable efforts made by the government and its partners, the situational analysis of present progress to reach MDG 1, 4, 5, 6 and 7 in Ethiopia shows that there remains a need for strengthening health systems & improving quality of health care. Wide ranges of high impact interventions are currently provided to Ethiopians or being considered for introduction at community, outreach and clinical service delivery levels.

The costing estimate uses two scenarios and each constitutes detailed costing analysis and results. Each scenario calls for a certain level of reinforcement of the cornerstones of the health system or the coverage determinants. A proportion of bottleneck reduction is considered to formulate the two Scenarios with separate set of coverage targets as detailed in Table 4.2a – 4.2c, many of the interventions exhibit low coverage levels. The assumptions implied in defining the scenarios are:

Comment [U3]: Macroeconomic justification

[5] The generic list of high impact interventions organized into three-service delivery mode: family/community, population oriented – both through outreach and on facility with schedule; delivery and skill management at health facility. The list is supported with the scientific evidence on efficacy and effectiveness from the various Lancet series (2003 child survival, 2005 neonatal survival, 2006 maternal, 2008 nutrition); the British Medical Journal (2005 for maternal); and the Cochran meta analysis by the World Bank, WHO and UNICEF in reviewing the literature on the efficacy of a list of interventions on reducing maternal mortality.

Base case Scenario: considers strategies to enhance the performance of the health extension program through skill upgrading of the health extensions workers, model family graduation, supportive supervision, and introduction of community based pneumonia treatment, as well further improving the quality of health services given at community level. It also includes strengthening the pastoral and urban health extension program. This scenario sets out high level of coverage with an ambitious reduction in existing bottlenecks of up to 80 percent over the coming five years this scenario is expected to bring about an achievement of 65% Model House old graduation, 46% Latrine Utilization, 38% Delivery by HEWs, and 100% & 65% ITN ownership and utilization by households respectively.. The base case scenario assumes that there is no compromisation in the achievement of MDGs by the year 2015.

This scenario also considers universal access to health center, staffing, equipping and availing drugs and supplies to HCs as per the standard and strengthening supply chain management system to make HCs fully functional and provide Basic Emergency Obstetric Care and essential newborn care. In addition, selected HCs will be upgraded to primary hospitals to provide ambulatory and inpatient services including emergency surgery, caesarean section and blood transfusion services and existing General and specialized hospitals will be strengthened. This scenario takes due consideration and uses the already achieved targets for infrastructure and HRH as a springboard for facilitating further health gains. These include the already achieved universal PHC coverage through rapid development of HPs at the community level, Health centers and the planned expansion and scale up of Primary \hospitals. It also considers the rapid development and deployment of the over 30,000 HEWs at the community level and over 5000 health officers at the Health center and hospitals. Consequently; it aims at reaching BEmONC and CEmONC services in 100% of HCs & hospitals respectively, 85% ART treatment, fully Immunization 90%; and 38% and 62% coverage in clean and safe delivery by HEWs and delivery by skilled attendants respectively. This scenario will achieve MDG target in maternal health through 54.8% reduction in MMR from the current levels. This scenario will achieve MDG target in child health through reduction of Under five mortality by 33.8% from the current levels.

Best case Scenario: It is in line with *MDGs Needs Assessment (2005)* that assumes no financial constraint. It is for fulfilling the commitment of the health sector to improve and sustain quality of health service delivery, embracing prevention and control of communicable diseases, and improving the quality of clinical care for both acute and chronic health problems. The assumption also include ensuring universal access to quality clinical care, and access to advanced treatment and care at all the health care delivery systems. The Best case scenario focuses mainly on evidence based high level clinical care and the protection of patient rights of accessing the needed health care services.

2.6. Cost and impact of scaling-up

Figure 4.1 presents the additional cost and impact in terms of mortality reductions for the two Scenarios. Base-case scenario stipulates the need to mobilize an additional US$ 11.96 per capita per year on average over the five years. The investment is estimated to reduce under five and maternal mortality by 31.8 percent and 54.8 percent, respectively. The Best case scenario calls for a higher additional investment of US$ 13.96 per capita per year resulting in a much higher reduction in under five and maternal mortality estimated at 46 percent and 56.6 percent, respectively. Ethiopia will be able to achieve the health MDGs with the implementation of the Base case Scenario. In terms of resource mobilization, the best case Scenario calls for almost doubling of the current Total Health Expenditure by the end of HSDP IV.

Figure 4.1: Additional cost, morbidity and mortality reduction estimates 2010/11 – 2014/15

Base-case Scenario		Base-case Scenario	
Under five	33.8%	Under five	46%
Maternal	54.8%	Maternal	56.6%
Cost per capita per year in US$	11.96	Cost per capita per year in US$	13.96

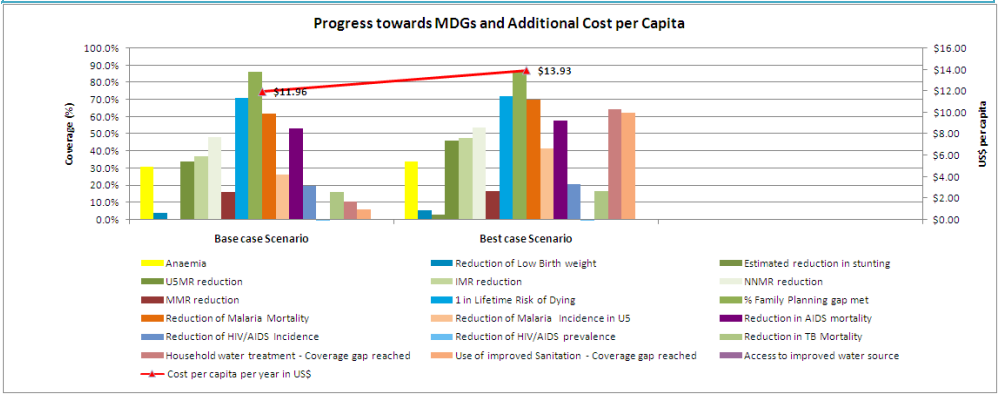


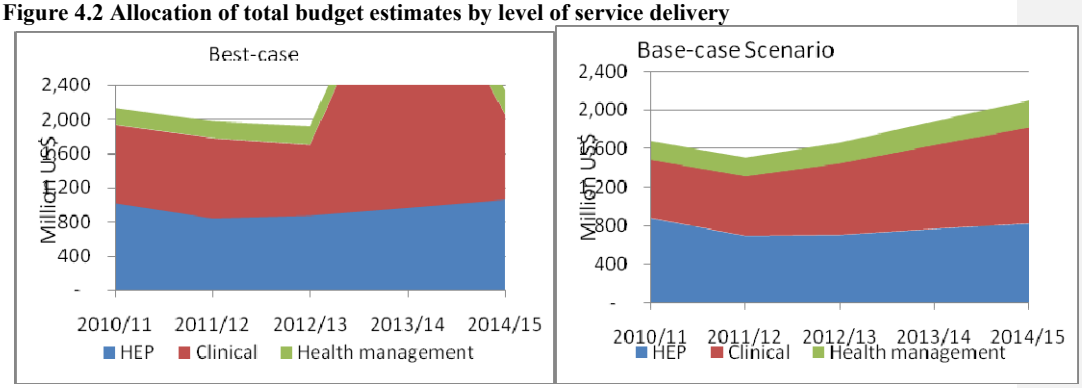
Figure 4.1: Progress towards MDGs and Additional Cost per Capita

The additional cost estimate is translated into total budget estimates for the five years. In calculating the total budget estimates the additional cost estimates are added to the baseline health sector spending for FY 2009/10. The health spending for 2009/10 consolidated based on the resource mapping which gathers all resources from Government and development partners on- and off-budget. The FY 2009/10 spending from Government and development partners is estimated at US$ 883.06 million. The summation of additional cost and FY 2009/10 spending is done for the recurrent portion only not to double count capital cost incurred in the past. The result presented by level of service delivery, recurrent capital investment distributions as well as by HSDP IV program areas.

Total budget for the five years is estimated at US$ 8.83 billion under the Base-case Scenario and US$ 10.828 billion for the Best case Scenario. This represent an average yearly increase of public health spending by 9 percent over the coming five years from the current base of US$ 883.06 million in the Base-case Scenario, and 13.5 percent increase under the Best case Scenario.

Level of service delivery: A substantial proportion of the total budget estimate allocated to make existing health facilities fully functional and improve quality of care at all level of the service delivery points. In both the Base-case and Best case Scenarios about 43 percent of the total budget is allocated to strengthen services at clinical level, including health centers, district and general hospitals. The investment is intended to enhance obstetric services with appropriate equipment, supplies and skills of the health workers. It also targets improvement in the quality of services available for maternal-newborn health, child health, nutrition, malaria, HIV/TB and non-communicable diseases. Over 45 percent of the total investment is aimed at sustaining and strengthening the Health Extension Program including the outreach services from health centers for immunization and family planning. About 15 percent of the total investment envisaged to further strengthen the health management and administrative capacity from Woreda Health Office, Regional Health Bureaus, to Federal Ministry of Health. (See Figure 4.2 below also Annex xx).

Figure 4.2 Allocation of total budget estimates by level of service delivery



Recurrent and capital investment allocations: In line with the decision to shift focus from expansion to service delivery and quality of care, a substantial proportion of the total budget estimate over the five years periods, 78 percent in the Base-case and 55 percent in the Best case Scenarios, is recurrent cost to cover salary, skill upgrading, supportive supervision, maintenance, and monitoring and evaluation. Only 22 percent in the Base-case and 45 percent in the Best case Scenario of the total budget estimate is for capital investment, mainly strengthen infrastructure capabilities for obstetric care. (See table 4.4)

Table 4.4. Base-case & Best case scenario: Total budget estimates for by service delivery, capital investment and recurrent, in Million US$

service delivery	Baseline	2010/11	2011/12	2012/13	2013/14	2014/15	Total	%
Base-case Scenario								
Population oriented schedulable services	63.39	351.06	125.27	137.31	152.49	167.51	933.64	33
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73	11
Family oriented community based services	181.76	527.17	568.60	567.44	615.00	655.68	2,933.89	43
Individual oriented clinical services	418.97	603.74	619.33	742.08	868.34	993.74	3,827.25	13
Total	883.06	1,677.01	1,507.07	1,662.54	1,883.51	2,096.38	8,826.50	100
Capital investment	628.74	581.01	382.68	347.83	337.83	327.41	1,976.76	22
Recurrent	254.32	1,095.99	1,124.39	1,314.71	1,545.68	1,768.96	6,849.74	78
Best-case Scenario								
Family oriented community based services	181.76	637.48	746.21	801.66	877.21	938.51	4,001.07	37
Population oriented schedulable services	63.39	389.65	196.52	179.25	194.75	209.99	1,170.17	11
Individual oriented clinical services	418.97	603.74	1,374.19	1,293.37	1,741.76	1,545.03	6,558.09	61
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73	10
Total	883.06	1,419.30	2,104.19	2,083.38	2,654.80	2,566.38	10,828.05	100
Capital investment	482.75	640.56	1,252.67	1,016.02	1,004.37	988.67	4,902.29	45
Recurrent	400.31	778.74	851.52	1,067.36	1,650.42	1,577.71	5,925.76	55

Budget estimates allocations to program areas: in the Base-case Scenario 48 percent of the budget is allocated to strengthening service delivery component of HSDP IV; followed by expansion and strengthening health infrastructure and resources 37 percent; and leadership and governance 15 percent. The three major programs, i.e. prevention and control of malaria, prevention and control of HIV/AIDS, and prevention and control of TB and leprosy account for 30 percent of the total budget estimate. (See table 4.5)

Table 4.5 Base-case Scenario: total estimated budget by HSDP IV program areas, in Million US$

Programmatic areas	Baseline	2010/11	2011/12	2012/13	2013/14	2014/15	Total	%
		Base-case Scenario						
1. Leadership and governance	33.85	181.47	193.90	259.95	330.56	396.39	1,362.27	15
1.1 Community Empowerment	6.78	17.48	29.95	34.31	37.85	40.07	159.65	2
1.2 Monitoring & Evaluation and Operational Research	7.36	15.36	24.05	29.35	33.53	36.57	138.85	2
1.3 System Strengthening & Capacity Development	19.71	148.63	139.91	196.29	259.19	319.74	1,063.76	12
2. Strengthening service delivery	626.12	738.73	801.56	819.06	885.90	949.44	4,194.69	48
2.1 Maternal-Newborn and RH-Adolscent Health	31.27	50.63	74.50	95.53	115.80	135.15	471.62	5
2.2 Child Health	25.06	37.95	43.01	45.04	48.46	51.24	225.70	3
2.3 Nutrition	6.38	13.56	19.89	22.91	25.29	26.63	108.27	1
2.4 Hygiene & Environmental Health	7.87	16.87	28.66	34.58	38.54	40.55	159.21	2
2.5 Prevention & Control of Malaria	111.45	240.53	202.06	137.51	120.79	103.46	804.36	9
2.6 Prevention & Control of HIV-AIDS	276.25	193.91	213.75	233.60	253.44	273.29	1,167.98	13
2.7 Prevention & Control of TB & Leprosy	152.72	131.96	137.04	141.70	146.22	150.61	707.53	8
2.8 Prevention & Control of Other Communicable Diseases	0.24	12.09	24.01	35.92	47.83	59.75	179.60	2
2.9 Prevention & Control of Non-Communicable Diseases	0.27	15.86	31.52	47.18	62.84	78.50	235.89	3
2.10 Public Health Emergency Management	0.45	6.54	7.07	7.10	7.49	7.76	35.97	0
2.11Public Health/Nutrition Research & Quality Assurance	14.16	18.81	20.05	18.01	19.19	22.51	98.57	1
3. Expansion & strengthening health infrastructure & resources	223.09	756.81	511.60	583.53	667.05	750.55	3,269.54	37
3.1 Expansion of PHC Facilities	39.48	273.94	32.62	44.17	55.71	67.25	473.69	5
3.2 Hospital Infrastructure	30.11	178.51	202.74	226.97	251.20	275.44	1,134.86	13
3.3 HR Salaries & Training	54.33	116.60	154.12	189.99	229.10	268.20	958.01	11
3.4 Pharmaceutical & Medical Equipment	97.00	184.51	115.65	112.74	118.18	123.62	654.71	7
3.5. Health Care Financing	2.17	3.24	6.47	9.67	12.86	16.04	48.27	1
Total	883.06	1,677.01	1,507.07	1,662.54	1,883.51	2,096.38	8,826.50	100

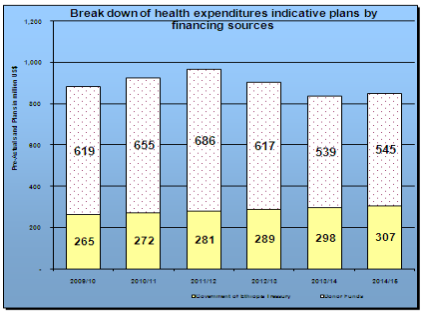
In the Best case Scenario 56 percent of the budget is allocated to strengthening service delivery component of HSDP IV; 31 percent for expansion and strengthening health infrastructure and resources: and leadership and governance 13 percent. Malaria, HIV/AIDS, and TB and leprosy taking a 40 percent share of the total estimated budget for the five years period. (See table 4.6)

Table 4.6 Best case Scenario: total estimated budget by HSDP IV program areas, in Million US$

Programmatic areas	Baseline	2010/11	2011/12	2012/13	2013/14	2014/15	Total	%
Best -case Scenario								
1. Leadership and governance	33.85	190.97	203.40	269.45	340.06	405.89	1,409.78	13
1.1 Community Empowerment	6.78	22.56	35.03	39.39	42.93	45.16	185.08	2
1.2 Monitoring & Evaluation and Operational Research	7.36	19.77	28.46	33.77	37.94	40.99	160.93	1
1.3 System Strengthening & Capacity Development	19.71	148.63	139.91	196.29	259.19	319.74	1,063.76	10
2. Strengthening service delivery	626.12	1,118.68	1,181.50	1,199.00	1,265.84	1,329.38	6,094.41	56
2.1 Maternal-Newborn and RH-Adolscent Health	31.27	72.07	95.95	116.98	137.25	156.59	578.84	5
2.2 Child Health	25.06	54.30	59.36	61.38	64.80	67.58	307.42	3
2.3 Nutrition	6.38	16.75	23.08	26.10	28.48	29.82	124.22	1
2.4 Hygiene & Environmental Health	7.87	18.06	29.84	35.76	39.72	41.73	165.11	2
2.5 Prevention & Control of Malaria	111.45	273.97	235.50	170.94	154.23	136.90	971.53	9
2.6 Prevention & Control of HIV-AIDS	276.25	367.94	387.79	407.63	427.48	447.32	2,038.17	19
2.7 Prevention & Control of TB & Leprosy	152.72	257.19	262.27	266.93	271.45	275.84	1,333.68	12
2.8 Prevention & Control of Other Communicable Diseases	0.24	12.27	24.19	36.10	48.01	59.93	180.50	2
2.9 Prevention & Control of Non-Communicable Diseases	0.27	16.06	31.72	47.38	63.04	78.70	236.90	2
2.10 Public Health Emergency Management	0.45	6.99	7.52	7.55	7.94	8.21	38.22	0
2.11Public Health/Nutrition Research & Quality Assurance	14.16	23.06	24.30	22.26	23.44	26.76	119.81	1
3. Expansion & strengthening health infrastructure & resources	223.09	767.67	522.47	594.40	677.91	761.42	3,323.87	31
3.1 Expansion of PHC Facilities	39.48	273.94	32.62	44.17	55.71	67.25	473.69	4
3.2 Hospital Infrastructure	30.11	178.51	202.74	226.97	251.20	275.44	1,134.86	10
3.3 HR Salaries & Training	54.33	127.47	164.99	200.85	239.96	279.07	1,012.34	9
3.4 Pharmaceutical & Medical Equipment	97.00	184.51	115.65	112.74	118.18	123.62	654.71	6
3.5. Health Care Financing	2.17	3.24	6.47	9.67	12.86	16.04	48.27	0
Total	883.06	2,077.32	1,907.38	2,062.85	2,283.82	2,496.69	10,828.05	100

2.7. Financing gap

The most significant constraints against the rapid scale up of health interventions are the prevailing inadequacy and inefficiency in the resource mobilization and allocation for health. Baseline and target coverage's (two scenarios) of high interventions included in the cost calculations are seen in the annex. Taking into consideration of the current poverty levels and the pace of the positive the country's economic growth, the estimated significant financing gap need to be filled through additional resource mobilization from all sources, with an inevitable of consequence that the substantial proportion of the resource requirement may have to come from development partners. The estimate under base-case scenario show that the country will require US$ 8.83 billion to implement its scale up strategies under HSDP IV and US$ 10.828 billion under Best case Scenario.



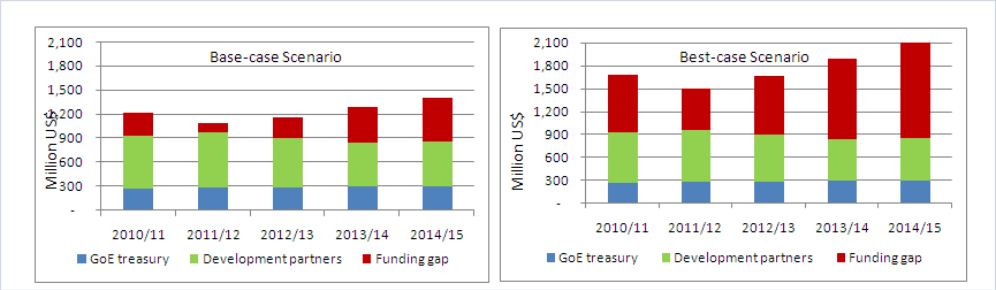
The contribution of Government to HSDP-IV is expected to follow an upward pattern with expected increased allocation from US$ 249 million in 2009/10 to US$ 307 million in 2014/15. As indicated in the figure 4.3, the projected resource commitment by 14 development partners in the coming five years of HSDP- IV periods shows some decline, especially in the last three years of HSDP-IV implementation. For some development partners the current country

cooperation program ends in 2009/10. Also the amount on donors' contributions has been incomplete as information from some donors has not been captured.

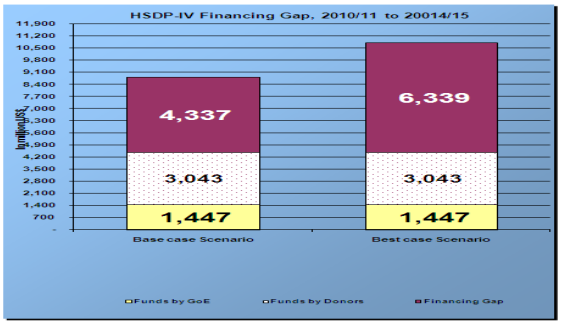
While progresses have been made on the fund pooling initiative with the introduction of the MDGs performance Fund, there still exists a major challenge in the predictability of donors funding. Most of the financing commitments are short-term and these are unpredictable. There is currently no firm commitment in terms of health financing beyond 2011/12, leaving a large uncertainty in terms of health services planning. In contradiction with the Paris declaration, the trends in the last several years having greater leaning towards a preference of earmarked project funding, rather than harmonized pool-funding. The trend so far clearly show that donors pledged amounts under an earmarked arrangement are larger than those amounts provided under a broader health system strengthening agreement. According to current pledges, a major financing gap remains for health systems in general, maternal-newborn and child health in particular.

To assess the funding gap for the implementation of HSDP IV the estimated total budget is compared to the projected resource commitment from Government treasury and development partners. As depicted in Figure 4.3 below both Base-case and Best case Scenarios encounter a substantial funding gap. In addition, the gap widen over time, as most development partners are not able to accurately predict for the later years of HSDP IV.

Figure 4.4: Funding gap over the five years period in Million US$



The financing gap for the Base-case Scenario amounts to US$ 4.337 billion and US$ 6.339 billion under the best case Scenario over the five years. This represents a yearly average funding gap of US$ 867.40 million and US$ 1,267.71 million for Base-case and s respectively. A disaggregated analysis of the financing gap by program areas confirms the inequity in the health sector. The major financing gap remains high in health systems including expansion and strengthening, pharmaceuticals followed by maternal-Newborn health and child health, see table 4.7 for the full detail of the funding gap for the best case scenario. While progress has been made on pooling with the introduction of the MDGs performance Fund, little has happened in terms of predictability. Most of the financing announced is short-term and has little predictability. There is currently no firm commitment in terms of health financing beyond 2012, leaving a large uncertainty in terms of health services planning. In contradiction with the Paris declaration the trend of the last years towards more



earmarked project funding, rather than harmonized pooled funding. Amounts pledged under an earmarked arrangement are larger than amounts provided under a broader health system strengthening agreement. According to current pledges, a major financing gap remains for health systems in general, maternal-Newborn health and child health.

Based on the information compiled from 14 development partners substantial amount of the commitment for the coming years is concentrated in few vertical disease specific programs. About 85 percent of the development partners projected commitment is for HIV/AIDS, TB and malaria. Though the vertical disease seems well fund in the previous years, there is still huge gap to scale those services to lower services delivery mode.

Table 4.7 Total budget estimate, projected commitment and funding gap by program areas

	Total budget estimate		Projected resource commitment	Funding gap 2010/11-2014/15	
	Base-case Scenario	Best-case Scenario		Base-case Scenario	Best-case Scenario
1. Leadership and governance	1,362.27	1,409.78	439.40	922.88	970.38
1.1 Community Empowerment	159.65	185.08	72.61	87.05	112.47
1.2 Monitoring & Evaluation and Operational Research	138.85	160.93	54.83	84.02	106.10
1.3 System Strengthening & Capacity Development	1,063.76	1,063.76	311.95	751.81	751.81
2. Strengthening service delivery	4,194.69	6,094.41	3,076.65	1,118.04	3,017.76
2.1 Maternal-Newborn and RH-Adolescent Health	471.62	578.84	154.49	317.13	424.35
2.2 Child Health	225.70	307.42	76.01	149.69	231.41
2.3 Nutrition	108.27	124.22	14.31	93.96	109.91
2.4 Hygiene & Environmental Health	159.21	165.11	34.69	124.52	130.42
2.5 Prevention & Control of Malaria	804.36	971.53	566.13	238.23	405.41
2.6 Prevention & Control of HIV-AIDS	1,167.98	2,038.17	1,395.12	- 227.13	643.05
2.7 Prevention & Control of TB & Leprosy	707.53	1,333.68	662.01	45.52	671.67
2.8 Prevention & Control of Other Communicable Diseases	179.60	180.50	72.53	107.07	107.97
2.9 Prevention & Control of Non-Communicable Diseases	235.89	236.90	72.33	163.56	164.58
2.10 Public Health Emergency Management	35.97	38.22	0.11	35.86	38.11
2.11Public Health/Nutrition Research & Quality Assurance	98.57	119.81	28.93	69.64	90.88
3. Expansion & strengthening health infrastructure & resources	3,269.54	3,323.87	973.45	2,296.09	2,350.42
3.1 Expansion of PHC Facilities	473.69	473.69	145.38	328.31	328.31
3.2 Hospital Infrastructure	1,134.86	1,134.86	144.94	989.92	989.92
3.3 HR Salaries & Training	958.01	1,012.34	454.04	503.97	558.30
3.4 Pharmaceutical & Medical Equipment	654.71	654.71	219.74	434.97	434.97
3.5. Health Care Financing	48.27	48.27	9.37	38.91	38.91
Total	8,826.50	10,828.05	4,489.50	4,337.00	6,338.55

2.8. Financing channels and arrangements for HSDP IV

Three channels of funding currently operate in the country, which also work for the health sector. These are:

1. **Channel 1a (un-earmarked)** is the disbursement channel used by Government itself. At each administrative level, the specialized Finance bodies control the release of funds and report upwards on their utilization. This is the channel that is used by donors providing budget support and PBS component-I.

   Channel 1b (earmarked) this channel is an earmarked fund transferred through MOFED, funds from each donor being tagged (with a two figure code), and sent to the region and zone/woreda (with a location code). The funds are reported on and accounted for separately, and used to pay only for activities agreed by the particular donor, often according to its specific procurement and disbursement procedures.

2. **Channel 2** is a channel whereby the Regional and Zonal/Woreda finance bodies are by-passed. Sector units at each administrative level expend and account for funds. There are variations on this channel. Some DPs centralize disbursement responsibility at the Federal level (so that even regional contractors are paid centrally). Other donors have worked directly with regional and/or woreda administrations.

3. **Channel 3**: in this channel of financing, DPs usually carries out any procurement and pays the contractor itself. Government merely agrees to, and budgets for, what is to be provided by the donor, and ensures that the expenditures are included in any overall HSDP accounting and auditing.

In-addition to the above three channels, there are two channels which operate specifically in the health sector. These are:

- **Technical Assistance Pooled Fund**:-this fund was established in 2005 by five DPs to provide support to FMOH. It fills critical gap in capacity and it is also the first of its kind in terms of pooling arrangement in the health sector. It provides support in technical assistance, sector reviews, operational research, and other activities at FMOH level. Currently the fund is being managed by UNICEF.
- **The MDG Performance Fund:-** the MDG Performance Fund and MDTF have also come to operation during HSDP III. MDG Performance Fund is described in HSDP-III and started working in 2007 with funds from GAVI for Health Systems Strengthening. A huge financing gap in health systems, maternal health, and the particular nature of health services – a large number of public good elements in service delivery and a high proportion of recurrent inputs bought internationally (medicines, commodities and equipment) – warrants the establishment of a strong Federal MOH Level MDGs Performance Package Fund to support the implementation of HSDP. MDG fund will finance the four thematic areas; Health extension program, Service delivery (MCH), Public health commodity procurement and Health Systems Strengthening. For further details on the management of MDG PF see the Joint Financing Arrangement.

2.9. Preferred Channels of Financing HSDP IV

For the health sector, the preferred modes are mainly i) the block-grant to woreda (currently supported by component 1 of the PBS project) and ii) the MDGs Performance Fund ("MDG Fund", currently supported by the 7 signatories of the JFA). These channels are preferred due to less transaction cost on the government.

2.10. Application of "one-budget" to the different channels and mechanisms

The main purposes of implementing "one budget" at all levels of the health system are 1)to make sure that various channels and funding mechanisms finance "one plan" and 2) to reduce transaction cost of the government because of having to deal with the various channels and financing mechanisms.

However, because of the listless progress prevailing in the sector in moving towards these financing mechanism, HSDP Harmonization Manual has proposed interim processes that will partially cater for these challenges. Accordingly, "financing of one-plan" could be realized by applying the following procedures.

- Making sure that all project supports are in line with the priorities in the sector.
- Information regarding project activities and funds allocated is provided to the local Government where the project is implemented in order to ensure that project activities are part and parcel of the "one-plan" at that particular level of the health system.
- Regular negotiation and discussion happens between local Governments and the project managers to allow flexibility, and avoid gaps and overlaps.
- Joint (with the local government and other stakeholders) monitoring and evaluation of project implementation takes place.

5. Management Arrangement of HSDP IV

This chapter describes the mandates of the different levels of the health system. It also gives elaborations to the planning, governance, procurement, financial management, monitoring and evaluation processes that applies to HDP IV.

2.11. Governance Structure

Annex 10

2.12. Inter-sectoral Collaboration and Public Private Partnership

There is increasing growing worldwide recognition that health is an integral part of sustainable socio-economic development efforts. In recent years, the United Nations Millennium Development Declaration has became a rallying call to improve health in all parts of the world. The millennium declaration focuses on broad, multi-sectoral approach to every efforts and national plans for development, including health. The overarching goal that any country should strive is achieving great improvement in the health of every citizen in the country. To achieve this lofty goal, countries should address, along with the provision of health care, the environmental factors that contribute to the society's collective health and illness by placing particular emphasis on the determinants of health. Health determinants are the range of personal, social, economic, and environmental factors that determine the health status of individuals or populations. Improvement in the health status of people therefore, cannot be fully achieved by only treating and managing diseases and injuries, but also require the collective actions by a wide ranging actors outside the health sector such as agriculture, infrastructure, education, environmental protection, etc. These actors may usually include government agencies at different levels, but other community groups also have also vital roles to play in the inter-sectoral collaboration for health efforts. Health sector provision itself can not the exclusive domain of the public sector, but it should be a collaborative endeavor through public/private partnership, the involvement of the NGO sector and private for profit health delivery system. The main organizational and operational challenge facing the health sector is in bringing all of these different actors together for a common pursuit and towards improving health through concerted action against major public health problems, in providing adequate and quality of care. Key sectors and mechanisms for intersectoral actionable collaborations during implementation of HSDP IV are indicated as follows.

- Collaboration with MOE on the training of health workers and school health promotion.
- Collaboration with the Ministry of Water Resources to ensure availability of adequate and clean water supply.
- Collaboration with the Ministry of Agriculture on nutrition, prevention and control of communicable diseases.
- Collaboration with the Ministry of Finance on improving resource allocation to the health sector.

- Collaboration with the media in public health awareness creation and dissemination of health messages and information to the general public.
- Collaboration with Ministry of Youth and Sports in adolescent health services.
- Collaborate with Ministry of Women Affairs on ensuring gender equality and maternal and child health services.
- Ministry of Transport on the reduction and prevention of road traffic accident and improvement in the efficient referrals of the injured.

Public Private Partnership will be enhanced through collaborative endeavors on selected health sector priority programs and health system issues such as:

- Collaboration with the private sector on the expansion of health infrastructure, local production of pharmaceuticals, provision of health services, training of health professionals and mobilization of resources for the health sector.
- Collaboration with professional associations in reducing professional malpractices towards improving quality of health services.

HSDP IV plan that the Inter-sectoral collaborations will be practiced at different levels of the health system through the formal government institutions (such as regional and woreda councils) and health sector governance structures (such as CJSC, RJSC and WJSC).

The major hallmark for Intersectoral collaboration is the initiation of joint planning, implementation, monitoring and evaluation at all levels of the health system as it has been elaborated in various documents (such as the HSDP Harmonization Manual). A complete set of manuals and tools will be developed to guide public private partnership in health.

2.13. Health Service Delivery Arrangement

The Ethiopian health service is restructured into three tier system. These are the PHCU which is composed of a HC and five satellite HPs. These provide services to 25,000 population altogether. HP is staffed with two HEWs. The HEWs are expected to spend less than 20% of their time in health posts, and more than 80% of their time is spent on community outreach program visitation to households, especially mothers and children. They provide 96 hours of training to households on the selected packages of HEP and follow the practice before certification and graduation of the households. HEWs provide family planning, EPI, OTP, clean delivery and essential newborn care services, diagnosis and treatment of malaria, diagnose and treatment of pneumonia including dehydration using ORS.

A HC is staffed with an average of 20staff. It provides both preventive and curative services. It serves as a referral center and practical training institution for HEWs. A HC has an impatient capacity of 5 beds.

A Primary Hospital provides inpatient and ambulatory services to an average population of 100,000. In addition to what a HC can provide, a primary hospital provides an emergency surgery service including Cesarean Section and gives access to blood transfusion service. It also

serves as a referral center for HCs under its catchment areas, a practical training center for nurses and other paramedical health professionals. A primary hospital has an inpatient capacity of 25-50 beds.

It is staffed by an average of 53 persons. It also serves as a referral center for HCs and a practical training center for nurses and other paramedics. A primary hospital has an inpatient capacity of 25-50 beds.

General Hospital provides inpatient and ambulatory services to an average of 1,000,000 people. It is staffed by an average of 234 professionals. It serves as a referral center for primary hospitals. It has an inpatient capacity of beds and serves as a training center for health officers, nurses and emergency surgeons categories of health workers.

A specialized hospital serves an average of five million people. It is staffed by an average of 440 professionals. It serves as a referral general hospitals and has an inpatient capacity of beds.

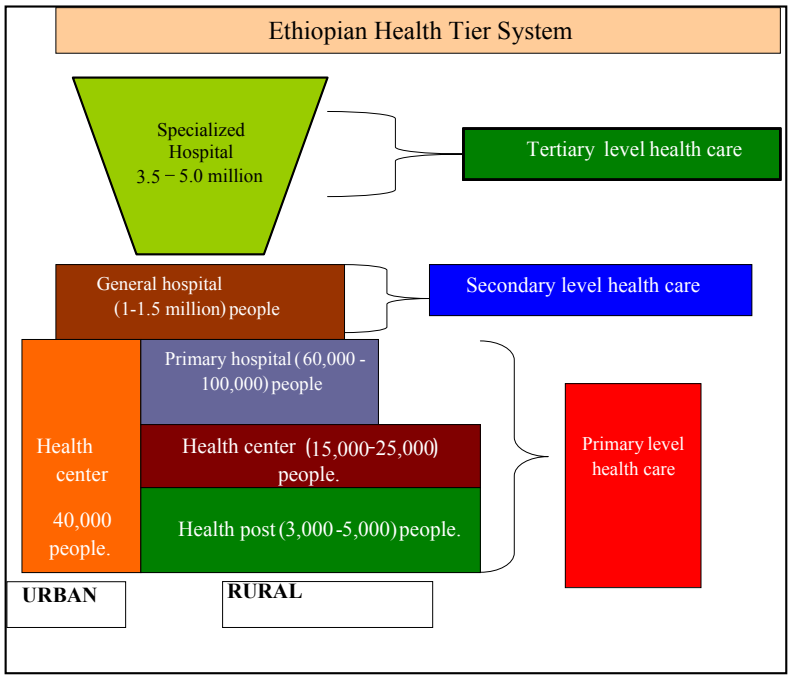


Figure 2: Ethiopian Health Tier System

2.14. Planning

The Ethiopian health planning is composed of two planning cycles. The first and the sigle most reference planning cycle is the five year strategic planning called HSDP. It serves as a blue print on which all Regional Health Planning and developed. The second is the annual planning that

translates the five year strategic planning into details of achievable targets, strategies and interventions under the different levels of the health care system.

In this respect, the commitment of the GOE to strengthen the implementation of one-plan in the health sector will continue throughout the HSDPIV period.

The following are the principles underpinning the planning process which applies to all stakeholders operating in the health sector at all levels.

1. **Government ownership and leadership to all health planning processes**. It means that the FMOH, RHBs, ZHDs, WorHOs at all levels of the health system own the process, have the responsibility to organize and lead the planning sessions and other processes.
2. **Consultation with all stakeholders**:- governmental, health development partners (DPs) NGOs, CSOs, private sector, etc will take part in the planning process in a spirit of partnership and will have roles to play and responsibilities to assume.
3. **Linkage to resource mapping from all stakeholders (government, donors, NGOs etc.) at that particular levels of the health system**:-all stakeholders will avail their expected resources commitment to the health sector every 3 years and confirm same every year. The resources need to be disaggregated by thematic and geographic areas to enhance evidence based planning and decision making at all levels of the health system.
4. **Approval of the plan and budget by the relevant local government authority through the formal political process**: - a comprehensive health plan will be presented to the council/parliament of the local governments to ensure government ownership, provide a clear picture of and resources activities in the health sector as well as to improve evidence based enhanced government resource allocation at all levels of the health system.
5. **Maintenance of Vertical (federal→regional→zonal→woreda) and horizontal linkage** (including activities of all stakeholders operating at that particular level):-the plans at all levels of the health system will make sure that national priorities are addressed at all levels of the health system while taking the local priorities into consideration. The targets set at a particular level of the health system will also be consistent with a cumulative average of the targets set by the lower levels repotting to that particular level of the health system. Besides, it is important that the activities of all stakeholders operating at a particular level of the health system be made part and parcel of the health plan of that level of the health system.
6. **Alignment of annual plans to strategic plans (in terms of priority and time) at all levels of the health system**:-annual plans represent the detailed operationalization of the five year strategic plan. It is therefore very important to make sure that annual plans reflect the priorities as well as the stipulated targets in sufficient details within the specified time frame.

Both strategic and annual planning are the results and consultations of top down and bottom up processes. The top down process ensures alignment of national priorities and targets with that of the regions and woreda's. It also helps to create consistency between the health sector plans and PASDEP and MDGs. The bottom up process ensures that the priorities and targets of regions and districts take local capacity into account. The details of planning process including the calendar of events, the role of stakeholders can be found in the annex.

It is important to note that annual plans are developed in two stages: the core plan and comprehensive plan. The core plan is about achieving national targets whilst the comprehensive plan is the core plan plus activities that are related to local health priorities. The source of Core

Plans district level planning that are compiled at the regional level which eventually consolidated to produce the Sectoral National Annual health Plan by the FMOH. This document is presented to the Annual Review Meeting (ARM) of the health sector each year.

The comprehensive annual plan constitutes the full core plan together with locally specific health issues. This is prepared at all levels, from facility to federal.

Comprehensive annual plans have the following features:

Scope: which should reflect all activities and budgets, including those implemented by the public sector, donor agencies, NGOs and communities.

Resource mapping and Financing: which provides estimation of the total amount of resources available from all sources: government, specific donors, internal revenue, NGOs, etc

Implementation schedule: a list of major activities, a quarterly/monthly implementation schedule and the responsible body for the implementation of each activity.

Monitoring framework: an established system for assessing progress during implementation. This includes key performance indicators, baseline data, annual targets, information sources and data collection mechanisms as well as reporting and feedback mechanisms.

2.15. Financial Management and Auditing

Financial Management can be defined as the management of the finances of a business / organization in order to achieve financial objectives. It refers to the various procedures and processes governing the flow of funds, through the stages of authorization, disbursement, payments, reporting, accounting and auditing. The function of auditing in a government body or in any organization is an essential element of public control and accountability. A good auditing system the management and financial controllers provide with a fair, objective and reliable assessment of the organization's performance thus helping maintain or restore credibility.

In this regard, the financial management of the HSDP-IV will be inline with existing government procedures. Regarding funds that are part of the block grant/direct budget support, the FGOE has set uncompromising standards of financial management. This has been confirmed by the results of various studies that the basic systems are already in place to ensure adequate control of public funds. In Ethiopia, the accounting system is sufficiently developed to track different sources of funding to final uses. The challenge remains on how to routinely monitor and report funding by HSDP component. It is envisaged that this will be facilitated through the harmonization of budget coding outlined in the Financing Plan.

The Ethiopian budget system separates recurrent from capital expenditure, the underlying principle is to distinguish the continuing running costs of government services from the discrete investment expenditures that add up to government assets. This distinction is however blurred due to the long tradition in the inclusion of external support within the budget 5. At present, the capital budget is composed of two different components: i) FGOE capital resources from domestic revenues; and ii) loans and grants/loans coming from external sources: bilateral and multilateral. Traditionally, all external funding is recorded under capital budget, regardless of the nature of expenditure supported by such funds. Again, in theory the FGOE accounting system enables the collation of financial data in sufficient detail to at least report on an ex post basis. In HSDP IV, a continued work will be undertaken to enhance financial management reporting.

Although regional states have a substantial degree of autonomy, the Federal Government takes the lead in setting financial management standards. The regions are also required to report their expenditure in the formats and at the times specified by MOFED. MOFED has overall responsibility for the management of public funds, including federal subsidies to the regional states. The Federal Office of the Auditor General (FOAG) is the supreme auditing institution of Ethiopia, with responsibility for auditing all federal funds, including subventions to the regional states. It is directly accountable to the Council of the Peoples Representatives.

In practice, all federal and regional offices are required to submit monthly reports on expenditure, and these serve as conditions for further disbursement. Quarterly and annual financial reports are also collated by different bodies as part of a progress report in the implementation of projects. To the maximum extent possible, these regular financial reports are used as the basis for financial monitoring of the HSDP. However, it is agreed that the standard systems may be supplemented, if necessary, with special reporting arrangements to ensure adequate monitoring.

The IFMIS which is contracted out is expected to bring remarkable improvement to the financial management, quality and speed of reporting to all stakeholders from all levels of the health system. In fact, IFMIS is a system that will facilitate the linkage of financial expenditure (performance) with physical implementation performance enhancing the efficiency and effectiveness of health programme management at all levels of the health system. The system which will ultimately be automated as a web based programme will provide access to information on physical performance and financial expenditure status of health programmes up to the level of districts.

Auditing of Regional expenditure is constitutionally the responsibility of regional auditors-general. However, regions may delegate responsibilities to the federal government. The federal government has also the right to instigate audits for all federally derived funds, which include all external aids and loans. Internal audit mechanisms continuously monitor financial management and proper adherence to financial and procedural regulations. The FOAG remains the independent auditor for the program. So far, one of the challenges encountered in this regard is delays in auditing due to various reasons. This will be taken up with the relevant authorities to fix the problem during the period of implementation of HSDP IV.

However, in accordance with the desire to move increasingly towards pooled funding and budgetary support, harmonized procedures such as the MDG Performance Fund have been put in place in order to minimize additional transaction costs for Government, and its management as indicated above.

2.16. Procurement and Logistics Management

The aim of a procurement procedure is to acquire goods and services in the most economic, efficient and transparent possible manner. The health sector in collaboration with DPs finalized the Logistic Master Plan in 2006. The Master Plan has outlined an integrated and efficient procurement system that reduces fragmentation of procurement management activities at national and sub national levels. As a result, PHARMID was changed to PFSA, a semi autonomous institution responsible for procuring and distributing pharmaceuticals, equipment and medical supplies to the public health institutions. Although the objectives, targets and

initiatives of pharmaceutical logistic management system have been indicated in the previous topics, it is worth elaborating the core activities of the Agency.

These are:

Selection and Quantification:-PFSA procures and distributes dugs and pharmaceuticals on the basis of the approved Essential Pharmaceuticals List (EHCL). This list is developed and updated utilizing the Ethiopian Essential Health Services Package and the Standard Treatment Guidelines, in order to match products to the primary health care programme, focus resources on essential and vital products. LMIS will be finalized, pilot tested and implemented in the public health sector. The data from this LMIS will be the basis for forecasting / quantification results for the essential pharmaceuticals of the public sector system.

Financing:-the Revolving Drug Fund (RDF) capacity will be enhanced to ensure adequate supply of the essential pharmaceuticals. It will be capitalized by Government/MOH and donor funds. The RDF covers operational expenses; capital replacement; and expansion; while protecting against inflation and losses due to a number of factors including expiration of drugs. Health facilities will retain and use user fee to procure pharmaceuticals. In the long run, the purchaser (health insurance agency) will be expected to be the provider of funds to health institutions to procure health commodities from there the nearest hub.

Procurement:-PFSA undertakes bulk procurement based on a medium term rolling procurement plan that will be prepared in collaboration with programme departments, Regions/Cities, and DPs. Procurement will be made according to the procurement legislation and procedures, expected to include domestic preference allowance for national manufacturers. All suppliers must be approved by Health Regulatory Agency (DACA) and products must be registered or have a specific exemption. Participation of local manufacturers will be stimulated. PFSA will also be in charge of procuring and distributing pharmaceuticals including equipment, medical supplies, vaccines, contraceptives, other PF commodities, etc financed by the MDG performance fund based on agreed administrative/management fee. Yet, FMOH will have the flexibility of using DPs with comparative advantage over PFSA to procure and distribute pharmaceuticals as deemed necessary.

Procurement planning is very important for the timely implementation of programs and activities. The starting point in any procurement is the preparation of a bid document. The content, arrangements and volume may vary according to the size and type (equipment, civil works, consultancy, ICB NCB, etc) of procurement to be done, but it should be clear and comprehensive and ensure that the goods/services are described with sufficient details to form the basis for competitive bidding. In a normal situation, the bidding documents would have been prepared, notices are given in the appropriate media with sufficient instructions, and bid documents should be ready for sale from the day the notices are printed or announced in the media.

Bid opening and evaluation procedures should and will comply with international and national standards. The major elements in the bidding process are the formation of a tender committee, the opening of bids in the presence of bidders, staged and detailed valuation of bids, determination of the three successful winners of the bid and notification of the top winner. Once the evaluation process is completed and the winners are identified, the successful bidder is promptly notified in writing, and is requested to sign a contract while the unsuccessful bidders shall be notified same as soon as possible.

Distribution (Storage and Transport):- distribution will utilize a network of 16 hubs/ warehouses the locations of which will be based on population density and operational feasibility. Regular orders from health institutions will be packaged and delivered by the hubs. The average transport costs will be included in the commodity sales price.

Inventory Management:-a robust inventory control system will be build in the public health facilities. The hubs and central warehouses will have automated inventory control tools to quickly process orders, manage stock according to best practices, provide security, and limit wastage and expiry. These warehouses will be physically organized following a standard model so that inventory management practices are enhanced (at minimum, through separate receiving, quarantine, storage, and dispatch areas).

Integrated Pharmaceuticals Fund and Supply Management Information System (IPFSMIS)):- IPFSMIS will be finalized and implemented to enhance the information flow within PFSA structure and with health facilities in order to gather information and use for logistics related decision making at all level. The net work will connect the central PFSA warehouse with major and secondary husband then with health facilities. The two way information flow helps the agency to get data on stock availability, consumption and new requirements from all health facilities and this will enhance to strengthen need based procurement and demand driven distribution. The logistics management system implementation allow the agency to communicate with its branches to gather data for forecasting, distribution, fleet management, Revolving Drug Fund, human resource and other general issues. There will be interface with other programs currently running at PFSA head office, branches and health facility level and data can be gathered ether on paper based or automated system. The existing different pieces of software at different level mainly on commodity trucking, inventory management, warehouse stock location and bar cod system, dispensing tools, and other appropriate systems will be interfaced to avoid duplication. The Integrated Pharmaceuticals Fund and Supply Management Information System (IPFSMIS) implementation project has identified the operational requirement at all level and its implementation will help the Agency to captured data from source at hub level and to compile for decision making and interventions.

2.17. Monitoring and Evaluation

Monitoring and evaluation (M&E) is an action-oriented and preplanned management tool that operates on adequate, relevant, reliable and timely collected, compiled and analyzed information on programme/project objectives, targets and activities. The objectives of M&E are to improve the management and optimum use of resources of programme and to make timely decisions to resolve constraints and/or problems of implementation.

The key elements for a successful programme management and implementation are the designing of a programme built on a hierarchy of objectives, targets, activities and measurable indicators. Agreed indicators are the most important management tools for monitoring, review and evaluation purposes. Indicators are always directly linked to the objective setting of a programme.

Monitoring of HSDP IV will draw significant lessons from the previous experiences, that suffered from the inadequate and poor quality of information for planning, monitoring and evaluation purposes. In oprder to improve M&E, the monitoring and evaluation system designed as part of the Policy, Planning and M&E core Process will be implemented at all levels of the

health system. Single results based framework with few indicators that make the monitoring and evaluation process effective and efficient will be agreed for the national level M&E system..

5.1.1. Routine Administrative report (HMIS)

While patient cards and registers are designed to capture all patient related data, reports will be based on the 107 sector wide indicators that have been jointly agreed and endorsed by the Government and DPs. The necessary resources will be allocated to put in place the human resources, tools and the equipment needed for the proper documentation, compilation, analysis, use and timely reporting of routine facility data as per the standard. All stakeholders operating in the health sector should support and use HMIS for programme monitoring. The indicators will be presented in the annex of this document.

Each health facility and administrative level will put in place the necessary institutional mechanisms (HMIS technician, or team) as per the standard indicated in the new design of HMIS. Data is collected from health facilities from client-patient records. The data will be aggregated and analyzed to compare plan versus performance for the facility's own consumption. Facilities will supply data to the relevant administrative levels through the routine reporting mechanism as per the HMIS reporting calendar. Validation of the data is done through Performance monitoring, ISS, surveys and regular inspections.

5.1.2. Performance Monitoring and Quality Improvement

Performance Monitoring: is the continuous tracking of priority information on conducted activities and the indicators of success in order to identify achievement gaps and lessons learnt as an input for subsequent leading to the planning and implementation of corrective measures. Quality Improvement Process is a performance monitoring activity by which health facilities (Hospitals, Health centers and Health posts) themselves use the opportunity of using locally available data generated during provision of health service to improve quality of health care through a continuous process of measurement and improvement. This aspect of M&E conducted based on Performance monitoring and Quality Improvement Standard Operating Procedure endorsed as part of PPME Core Process that clearly outlines the fundamental building blocks of performance monitoring and quality improvement i.e. Quality Planning, Quality Performance Measurement, Quality Improvement Activities, Staff Involvement, Evaluation of Quality Program, and Clinical Information System.

5.1.3. Evaluation/Operational Research

Evaluation is a well thought systematic approach which may be designed to determine the value or worth of a specific program, intervention or project or any of its components to be able to link a particular output or outcome directly to a particular intervention.

Program evaluation requires a systematic process of data collection, analysis and interpretation about interventions and their effects about a program or any of its components in pursuit of looking answers to evaluation questions. It fundamentally consists of making a value judgment regarding an intervention, a service or regarding any one of their components, purposing to help in evidence-based decision making.

In such evolution processes, some issues may require further detailed investigation to get clear picture of the "whys" of program performances or achievements. Such evaluation questions will be addressed by program evaluation. Program evaluations may be either process evaluation,

which examines the appropriate execution of program components, or outcome evaluation, which examines the worth of implementing an intervention or any of its components.

It is technically impossible to obtain all health and health related data exclusively through HMIS. Hence, regular demand side and supply side surveys will be conducted to capture selected set of data and triangulate various sources in order to improve the accuracy of outcomes and impacts of health interventions. The major principles that underpin this activity are: 1) the data set need to be mutually agreed between the Government and DPs, 2)the surveys should be conducted by/under the leadership of the Government in defined frequency 3) timing of the surveys should align with the Government calendar 4) DPs should provide adequate resources (financial and technical).

Assessments could also be conducted to measure the performance of a certain health system issue or to verify if commitments or intended results in relation to specific agreements have been realized. The case in point is regular assessment of the adherence of stakeholders to the principles of one-plan, one-budget and one-report.

Manuals and tools produced for evaluation/operational research will be used during the implementation of HSDP IV.

5.1.4. Integrated Supportive Supervision (ISS)

Integrated Supportive Supervision can be defined as a process of guiding, helping, training, and encouraging staff to improve their performance in order to provide high-quality health services through the use of integrated tools for all priority programs and empowering of health service providers at all levels.

A guideline and tools for ISS have been finalized as part of the BPR. Hence, these will be put to use during the implementation of HSDP IV.

5.1.5. Inspection

In the process of monitoring and evaluation, issues which are related with performance based financing and other most priority and emergency situations need a mechanism for verification of routine reports attached with accountability. This will be addressed by inspection which will be established at all levels in the health sector. Unlike ISS which focuses on onsite support provision, inspection is primarily to prove activities and make institutions accountable for their level of compliance with agreed upon levels of performance.

The necessary manuals and tools for implementation of inspection have been finalized as part of PPME BPR. Hence, these will be fully implemented during HSDP IV.

2.18. List of Key Indicators for Result Framework at National Level

Indicators measure progress towards the agreed objectives and targets. Indicators with target for each strategic objective are listed in chapter three under 3.6 and a comprehensive list of indicators to monitor all programmatic areas in HSDP IV is annexed. The following are only selected list of indicators that should be made available on at least annual basis (or more frequently). Listing the indicators below does not imply that other indicators will not be made available. In selecting these indicators, reference is made to HMIS indicators, various

programmatic indicators, and result framework agreed as part of IHP+. Detailed description of methods, frequency and responsible body for collecting these indicators is found in the annex.

MNCH

1. Contraceptive Acceptance Rate
2. Focused ANC 1+
3. Proportion of deliveries attended by skilled health attendants
4. Proportion of deliveries attended by HEW
5. Post natal care coverage
6. Proportion of pregnant women who receive ANC at PMTCT site who received testing for HIV
7. Proportion of deliveries of HIV+ women that receive full course of ARV prophylaxis
8. Immunization coverage; Pentavalent 3, Rotavirus, Pneumococcal, measles and fully Immunized
9. Protection at birth against neonatal tetanus
10. Health facility with services like PMTCT, BEmONC, CEmONC, IMNCI, Youth friendly services

Disease Prevention and Control

1. PIHCT testing rate
2. VCT testing rate
3. Cumulative number of PLHIV ever enrolled in HIV care
4. Cumulative number of PLHIV ever started on ART
5. Proportion of patients who are currently on ART
6. TB Case Detection Rate
7. TB cure rate
8. TB treatment success rate
9. Proportion households in malarious areas posses at least one LLIN

Proportion of households in IRS targeted areas that were sprayed in the last twelve months

Nutrition

1. Children 6-59 months given vitamin A every 6 months
2. Children 2-5 years dewormed every 6 months

Hygiene and Environmental Health

1. Proportion of households using household water treatment and safe storage practice
2. Proportion of households utilizing latrine

Health Infrastructure

1. Number of new Health Facilities constructed (by type)
2. Number of Health Facilities upgraded (by type)
3. Proportion of health facilities with latrine and with functioning water supply
4. Proportion of Health facilities with water supply
5. Number of hospitals implementing EMR
6. Number of hospitals implementing tele-medicine

Human Resources

1. Health Staff to population ratio by category
2. Proportion of institutions staffed as per standards

Pharmaceutical supply and services

1. Average stock out duration Essential drug availability
2. Percentage of stock wasted due to expiry

Community Ownership

1. Proportion of model households graduated

Proportion of health facilities with boards where communities are represented

Quality Health services

1. Inpatient mortality rate
2. Customer satisfaction index
3. Outpatient (OPD) attendance per capita
4. Bed Occupancy Rate
5. Average length of stay (ALOS)

Public Health Emergency preparedness and Response

1. Proportion of epidemics averted (AWD, malaria and meningitis)
2. Proportion of epidemics controlled with zero mortality

Evidence based Decision Making

1. Proportion of partners implementing “one-plan”
2. Proportion of partners providing funds as DBS or MDG PF
3. Facilities implementing the new HMIS/M&E System (by type of facility)
4. Completeness and timely submission of routine health and administrative reports
5. Review meetings conducted by level

Resource Mobilization and Utilization

1. Percentage of government budget allocated for health

2. Facilities retaining and utilizing revenue (by type)
3. The ratio of health budget utilization to allocation

2.19. Risk Mitigation

Comment [U4]: Newly added

One of the major risks the HSDP IV can face is inadequacy in financial resources. As it is indicated in the costing chapter, there is US$ 4.34 billion gap for the to achieve MDGs. First of all, the strategic objective resource mobilization and utilization clearly states how effectively and efficiently resource will be mobilized and utilized. Therefore, there will be proactive resource mobilization from external source using the different mechanisms stated in the resource mobilization business process reengineering. The health insurance is one of the internal mechanisms that is expected to increase financing to the health sector.

Improving community ownership and strengthening public-private partnership are additional mechanisms that will improve health care financing besides improving utilization of quality health care services. More details of the risks anticipated for the supply and demand side are identified and solutions to tackle them are well addressed in chapter three (SWOT and stakeholder analysis, strategic objectives and strategic initiatives).

Annex 1: Challenges and Implementation Gaps of HSDP III and linkages to HSDP IV

Areas	Challenges	Recommendations	Strategies
Maternal, Neonatal, Child and Adolescent Health	Absence of 24 hours a day and 7 days a week services in most health facilities especially in health centres & unavailability of HEWs on weekend/night	Provide round the clock delivery services in health centres.	Strengthen facility based maternal, newborn, child and adolescent health services.
		Improve quality of service provision	Implement BPR in all health facilities.
	Low quality of service provision (Long waiting time, poor counseling service, lack of privacy)	Implementing Emergency Triage Assessment and Treatment (ETAT).	Introduce the training of emergency medicine by 2010 to improve the emergency medical service
	Inadequate organization of hospital services to effectively handle emergencies.	Provide comprehensive Emergency Obstetric Care (CEOC) at all hospitals and selected health centres.	Strengthen Basic and Comprehensive EmONC
	Shortage of adequate and safe blood	Accelerate the completion and functionality of the new blood banks.	Improve referral system including pediatric referral system.
	Poor delivery room environment and poor attitude of the health workers	Ensure the provision skilled delivery services in all HCs	Improve contraceptive logistics information system
	Service inaccessibility & transportation problem	Establish separate neonatal units in hospitals.	Improve availability of long acting contraceptives
	Absence of separate neonatal units in most of the hospitals	Enhance referral system	Strengthen multispectral collaboration on newborn, child and adolescent health programs.
	Weak referral system, service integration and supportive supervision.	Improve contraceptive logistics information system	Scale up of midwife training
	Shortage, high turnover, and insufficient skill of midwives and delivery attendants due to poor quality of training	Improve availability of long acting contraceptives	Capacity building on program management for maternal and child health services.
	Slow procurement and distribution of medicines and supplies leading to shortage at service delivery point & Poor stock management	Scale up quality training for midwives and improve the skills of HEWs through strengthening of clean & safe delivery trainings	Increase net financial and non-financial incentives for rare skill professionals who would be assigned in rural areas
	Lack of FP Method mix	Ensure motivation scheme & Reward for best performances	Strengthen supply chain management (including social marketing)
	High family planning unmet need	Strengthen the supply chain management system, effective LMIS and procurement	Strengthening logistic management information systems.
	Limited availability of adolescent and youth friendly reproductive health services	Expansion & Integrate FP service with other services	Scale up family planning program with focus on long-term options
	Lack of awareness & misconception on RH & CH Services	Women empowerment and encourage male involvement in family planning	Much stronger RH-HIV integration, (in particular FP-HIV prevention linkages through common messages and dual protection)
	Religious & cultural problems & traditional practices/beliefs	Provide adolescent and youth friendly RH services.	Enhance Youth Friendly services.
	Low health seeking behavior	Increase awareness creation through social mobilization and community conversation	Launch Social Mobilization
	Insufficient resources	Rapid rollout of pneumonia treatment and other common childhood illnesses through HEP.	Strengthen IMNCI service at health facilities and community levels.
		Ensure the provision IMNCI services in all HCs	Strengthen routine immunization.
		Resource mobilization(advocate more resource flow towards	Strengthen proactive resource mobilization
			Enhance coordination and harmonized approach among all partners.

Areas	Challenges	Recommendations	Strategies
		maternal health)	
Disease Prevention and Control	Ineffective use of HEP for prevention and control of TB leading to low community awareness and demand for the servicexxxiv. Weak diagnostic laboratory services. Poor follow up on HCs to start DOTS service Inaccessibility of AFB diagnostic services Poor diagnostic skill and (high proportion of smear negative and EPTB) Poor referral linkages between HP and HCs Inadequate community participation on environmental management of vector control; low IRS coverage and resistance to DDT. Low usage of ITNs by households in some areas. Recurrent malaria epidemics and outbreaks diverting attentions from prevention control program. Shortage of HIV test kits and supplies & poor stock management Inadequate management and support to PMTCT leading to low coverage. Low performance of PMTCT/MNCH /SRH services in urban and semi urban health posts. Weak integration of ANC with PMTCT Shortage of OI drugs Low performance of STI services & TB/HIV collaboration Slow implementation of programs to tackle NCDs	Ensure effective use of HEP for prevention and control of major communicable diseases. Expansion of DOTS service to all HPs / community DOTS and to all HCs Enhance laboratory capacity at all levels as per the BPR design and expand the AFB diagnostic services to all HCs and hospitals Intensify referral linkage and feedback Introduce PICT for TB (active case finding strategies) to all OPD visitors, PLHIV, household visits by HEWs, Expand MDR –TB management to all tertiary level hospitals. Enhance emphasis on environmental management specifically strengthen IRS Increase emphasis on IEC/BCC to translate high levels of net ownership into utilization. Rapidly implement the Public Health Emergency Management Core Process at all levels. Strengthen effective LMIS and procurement and Ensure availability of HIV test kit & supplies Enhance the integration of HCT and PMTCT in RH services as per the BPR design. Improve availability of OI/STI drugs Improve TB HIV collaboration Expand the PMTCT services at all health facilities level Increase awareness through community conversation and mass media	DOTS expansion and enhancement through maximum use of HEP as a vehicle to detect new cases, contact tracing and treatment follow up. Upgrade laboratory networks, and implement the Practical Approach to Lung Health (PAL) Ensure early case detection, and diagnosis through quality-assured bacteriology Improve information systems, including notification and referral routines. Scale-up collaborative TB/HIV activities. Scale-up prevention and management of multidrug-resistant TB (MDR-TB). Community Empowerment and Mobilization Selective vector control (ITN, IRS, Environmental management) Early diagnosis and treatment of cases of malaria. Strengthen epidemiological and laboratory Disease Surveillance through implementation of Public Health Emergency Management Core Process at all levels. Strengthen supply chain management Strengthening logistic management information systems Create access and quality of chronic HIV/AIDS care and treatment (through enhancing service integration, laboratory, referral, availability of essential commodities, public private partnership and addressing human resource issue) Enhance PMTCT service through integration with MNCH and linkage with HEP. Expansion of Routine HIV testing during ANC Strengthen Community mobilization and male involvement Establish program management and coordination structure for control of NCDs Advocacy, Social Mobilization and Sensitization for NCDs program implementation Develop and sustain partnership and collaboration for integrated NCDs control

Areas	Challenges	Recommendations	Strategies
Health Extension Program	Inadequate skill based trainings of HEWs particularly on conducting delivery. Attrition and absence of the HEWs from their catchments areas; Slow carrier development for HEWs; Lack of community ownership Low performance in completion of model household training due to poor follow-up Low WASH facilities at HP level and inadequate awareness.	Enhance sustained commitment of the leadership to program implementation. Enhance coordinated Integrated Refresher training (IRT). Assess and improve the effectiveness of ISS model between the WoHO, health centers, supervisors and HEWs; Finalize and implement carrier structure for HEWs; Enhancing the capacity of public and private sectors on WASH. Improve WASH knowledge and facilities at HP level Link health facilities with WASH to improve water supply	Strengthen Integrated Refresher Training for HEWs Strengthen supportive supervision and Motivation Develop curriculum and implementation manual for career development of HEWs Strengthen Health Extension Programs Enhances community ownership via Model family graduation Strengthen water supply safety measures Community Led Total Sanitation and Hygiene Strengthen Coordination & collaboration of sectors
Other Health System Issues	Poor quality of Health services. Low fiscal space and poor staff absorption capacity of the health system Persistent critical funding gap for health systems. Poor predictability of donor funds. Inadequate capacity for fund liquidation, reporting and auditing of funds in the sector. Slow progress in terms of harmonizing donor procedures with that of the Government. Uncoordinated and misguided research efforts among various stakeholders Poor dissemination and translation to action of research results Slow implementation of HMIS leading to incomplete and inconsistent reporting. Delay in construction of HPs and Health Centers;	Implement the PMQ standard and Health and Health Related Regulatory Core Process. Improve budget allocation to the health sector specifically to health systems Improve implementation of HCF reforms and FRM Core Process. Improve accountability and strengthen the financial management system through the design and implementation of IFMIS. Continues monitoring of IHP+ Compact. Effective research coordination, prioritization, dissemination and use Enhance the implementation of HMIS/ M&E system. Accelerate the construction of HPs and Health Centers.	Implement BPR in all health facilities. Strengthen regulatory service to both public and private sector institutions. Strengthen inspection and licensing Implement performance review as part of M&E. Evidence based planning and budget allocation. Scale up health care financing reform Strengthen Proactive resource hunting. Introduce Social and community health insurance. Introduce Integrated Financial Management Information System Strengthen financial management and accountability development program Advocate one plan and one budget and one reporting framework Strengthen regular adherence evaluation. Effective implementation of the Research and Technology Transfer Core Process Scale up M&E/HMIS. Accelerated expansion of health facilities
Nutrition	Inadequate capacity of HEWs and community promoters Lack of sustained promotion on breast feeding Harmful traditions Lack of Infant formula code/ proclamation Lack of knowledge of mothers on exclusively breastfeeding	Strengthen and sustain promotion of community-based nutrition Increase awareness of Health professionals and mothers on breast feeding Enact Code of infant formula implementation	Expansion of Community Based Nutrition (CBN). Sustaining Enhanced Outreach Strategy, (EOS) with Targeted Supplementary Food, (TSF) and Transitioning of EOS into HEP. Health Facility Nutrition Services. Essential Nutrition Actions/Integrated Infant and Young Feeding counseling services.

Annex 2: Summary of the result of the bottleneck analysis conducted for HSDP IV (Linking key interventions and strategies to Health system bottlenecks)

1a. Family oriented community based services

	Major system bottlenecks	Possible causes	Proposed operational strategies/solutions
Family Preventive/WASH Services	Availability and capacity of HEWs and community promoters Low utilization of services	• Inadequate capacity of HEWs and community promoters • Inadequate number of HEWs and community promoters • Attrition rate of HEW • Lack of community ownership • Inappropriate communication approaches • Expectation of supplies for household level health interventions by the community • ITN not suitable with the housing & weather condition in some areas	• Integrated Refresher Training for HEWs • Supportive supervision • Motivation(carrier, rewards) • Enhances community ownership via Model family graduation • Accountability matrix for community empowerment • Inter-regional or local best practice experience sharing • Strengthen health promotion • Coordination & collaboration of sectors
Family neonatal care	Availability essential commodities Availability and capacity of HEWs Low utilization of services	• Inadequate supply of clean delivery kits • Low water supply & poor sanitary system of health posts • Inadequate HEWs trained on clean & safe delivery, Insufficient skill • Unavailability of HEWs on weekend/night • Transportation problem • Low quality of service provision • Low health seeking behavior	• Strengthen supply chain management • Local assemble of kits for safe & clean delivery • Frequent and organized distribution of kits • Link with WASH to improve water supply • Avail alternative/ solar power • Strengthen and expansion of clean & safe delivery trainings • Strengthen Health promotion • Improve quality of service provision • Enhance free service • Increase communication/referral linkage
Infant and child feeding	Availability essential commodities Availability and capacity of HEWs Low utilization of services	• Inadequate capacity of HEWs and community promoters • Lack of sustained promotion on breast feeding • In adequate professional attitude on advantage of early feeding • Harmful traditions • Lack of Infant formula code/ proclamation • Lack of knowledge of mothers on exclusively breastfeeding • Occupational influence	• Strengthen and sustain promotion of community-based nutrition • Increase awareness of Health professionals on breast feeding • Enact Code of infant formula implementation • Baby friendly Hospital Initiative • Improve low cost technologies to reduce work load of care givers
Community Management Illnesses	Availability essential commodities Availability and capacity of HEWs Low utilization of services	• Inadequate supply and lack of continuous refilling of ORS and ORT • Lack of knowledge of mothers on the advantage of recommended home fluids	• Strengthen supply chain management including social marketing • Enhance the availability and importance of ORT corners • Strengthen promotion of on additional fluid and feeding for children with diarrhea

1b. Population oriented schedulable services

	Major system bottlenecks	Possible causes	Proposed operational strategies/solutions

	Major system bottlenecks	Possible causes	Proposed operational strategies/solutions
Preventive care for adolescents and adults	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Stock supply problem • Lack of awareness & misconception • Limited fiscal space for hiring staff • Religious & cultural problems • Weak service integration and linkage • High family planning unmet need • Lack of FP Method mix • Inadequate long acting contraceptives. • Weak contraceptive LMIS • Lack of decision making by women • Lack of communication skills of the health care providers	• Increase contraceptive commodities supply • Expansion of health facilities and provision of the family planning services • Increase awareness creation through social mobilization and community conversation • Improve contraceptive logistics information system • Improve availability of long acting contraceptives • Integrate FP service with other services • Women empowerment and encourage male involvement in family planning
Preventive pregnancy care	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Inadequate/inaccessible functional primary health facilities • Poor quality of service (Long waiting time, poor counseling service, lack of privacy) • Low perceived benefit by pregnant women	• Expansion of health facilities services • Increase awareness creation through social mobilization • Service integration • Increase model families graduation • Improve inter-personal communication and counseling skills
HIV/AIDS prevention and care	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Shortage of HIV test kits and supplies • Inaccessible service • Weak integration of ANC with PMTCT • Lack of awareness about the PMTCT service	• Ensure availability of HIV test kit & supplies • Pre-service training for health professionals • Enhance inter-sectoral partnership with development partners • Expand the PMTCT services at all health facilities level • Service integration • Improve quality of service to create demand • Increase awareness through community conversation and mass media
Preventive infant & child care	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Shortage of supplies such as vaccine and injection materials (Cold chain) • Geographical location barriers • - Transport problem • Communication problem of care provider • Low vaccine efficacy monitoring system • Refrigerator maintenance & spare problem	• Improve supplies • Improve cold chain management and vaccine storage system, Provide training on cold chain management • Increase awareness and social mobilization activities • Intensify regular Campaign to enhance service coverage

1c. Individual oriented clinical services

	Major system bottlenecks	Possible causes	Proposed operational strategies/solutions

	Major system bottlenecks	Possible causes	Proposed operational strategies/solutions
Clinical primary level skilled maternal & neonatal care	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Insufficient resources • Poor stock management • Prolonged procurement & distribution process • Lack of Access to water supply • Inadequate number of trained midwives • High turnover of trained professionals/poor motivation • Inaccessibility • Poor quality of service • Concomitant traditional practices/beliefs	• Resource mobilization(advocate more resource flow towards maternal health) • Strengthen effective LMIS and procurement • Continued quality midwifery training • Ensure motivation skim • Speed up HCs construction • Ensure the provision skilled delivery services in all HCs • Improve quality of service • Intensify Advocacy Communication and Social Mobilization(ACSM) • Reward for best performances
Management of Illnesses at Primary Clinical Level	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Insufficient resources &poor stock management • Lack of Access to water supply • Inadequate number of trained Health professionals on IMNCI • High turnover of trained professionals/poor motivation • Service inaccessibility • Poor quality of service • Poor attitude/health seeking behavior of care takers	• Resource mobilization • Strengthen effective LMIS and procurement • Continued quality of training • Ensure motivation skim • Speed up HCs construction • Ensure the provision IMNCI services in all HCs • Improve quality of service • Intensify Advocacy Communication and Social Mobilization(ACSM) • Reward for best performances
Clinical first referral illness management	Availability of supplies Availability/ capacity of Health workers Accessibility of services Low utilization of services	• Insufficient resources • Poor stock management • High turnover of trained professionals/poor motivation • Service inaccessibility • Poor attitude/health seeking behavior of care takers • Poor follow up on HCs to start DOTS service • Poor Health seeking behavior for early diagnosis • Poor referral linkages between HP and HCs • Passive case finding methods • Inaccessibility of AFB diagnostic services • Poor diagnostic skill and (high proportion of smear negative and EPTB) • Poor adherence to case finding algorithms, Poor contact tracing • Inadequate Drug Sensitivity Testing(DST) and second line treatment options	• Resource mobilization • Strengthen effective LMIS and procurement • Expand DOTS service to all HCs • Expand the AFB diagnostic services to all HCs and hospitals • Intensify referral linkage and feedback • In-Place PICT for TB (active case finding strategies) to all OPD visitors, PLHIV, household visits by HEWs, • - Build the diagnostic and case finding capacity of health professionals • Improve tracing all contacts of known smear positive TB cases • Expansion of DOTS service to all HPs / community DOTS • Advocate to do the last microcopy and declare cure to all smear positive TB cases • Build the capacity the drug quality testing capacity at country level • Expand DST service and ensure diagnosis of all re-treatment/category II cases • Expand MDR –TB management to all tertiary level hospitals

Annex 3: Projection of Human Resources Requirement

HRH Category	2015	2020
Internist	730	910
Pediatrician	719	940
Obstetrician	820	1,094
Surgeon	847	1,024
Orthopedics	283	418
Ophthalmologist	304	524
Dermatologist	202	273
Psychiatrist	304	410
Radiologist	316	415
ENT Specialist	210	349
Anesthesiologist	233	309
Clinical Pathologist	210	275
Dentist	633	1,770
General Practitioner	10,846	14,792
Health Officer	6,345	8,293
IESO	996	1,611
Nurses	41,009	49,362
Midwife	8,635	9,866
Pharmacist	2,037	2,779
Pharmacy Technician	8,704	9,839
Laboratory Technologist	1,133	1,567
Laboratory Technician	10,608	12,845
Radiographer	1,954	2,796
Psychiatric Nurse	923	1,360
Physiotherapy professional	550	746
Dental Professional	1,145	2,385
Environmental and occupational Health Worker	1,595	1,961
Biomedical Technician	874	1,256
Public Health Specialist	1,400	2,158
HIT	7,607	8,849
Hospital Manager	650	986
HEW	33,320	41,664
Total	146,142	183,826

Annex 4: Planning and Budgeting Calendar

	Annual planning activities	Time-frame	Involved Parties
	Federal Ministry of Health		
1	Mapping of next year's resources at FMOH level	10 February	All departments of FMOH in consultation with MOFED and health partners
2	Develop a draft annual Core Plan and share it with RHBs	28 February	All departments of FMOH
3	Finalize the Core Plan at FMOH-RHBs steering committee meeting	9 March	FMOH-RHBs Joint Steering Committee members
4	Workshop on FMOH capital and recurrent budget proposal to MOFED	10 March	All departments of FMOH
5	Finalization of FMOH capital and recurrent plan and submission to MOFED	23rd March	All departments of FMOH
6	Set up, orient and deploy teams of Technical Assistance (TAs) to assist RHBs, ZHDs, and WorHOs in the preparation of core plans	13 to 18 March	PPD/ FMOH
7	Prepare a Sectoral National Annual Plan based on the core plans of the RHBs, FMOH activities and activities of all stakeholders obtained through a consultative process.	April 20	PPD/ FMOH , partners
8	Revise and finalize the Sectoral National Annual Plan based on the approved regional/woreda annual core plans	June	PPD/ FMOH
B	Regional Health Bureaus		
1	Conduct consultation with stakeholders to identify available resources and discuss priorities and targets	15 February	RHBs in consultation with BOFED, FMOH and health partners in the respective regions
2	Based on the agreed Core Plan and the resources available, regions will prepare a draft Regional Core Plan that indicates priorities, targets and key activities and share it with woredas.	March 18	
3	Guide and assist the WorHOs to complete the planning information format produced by FMoH	March 14-26	RHBs and Technical Assistants
4	Organize and guide Regional Planning Workshops to discuss and refine the woreda annual health plans	March 27-April 13	RHBs /ZHDs
5	Consolidate the Regional Core Plan and submit to the FMOH/PPD.	April 18	RHBs
6	Revise and finalize the regional annual core plan based on the approved woreda, regional and zonal budgets and communicate to the FMOH/PPD	June	RHBs
C	Zonal Health Departments		
1	Participate in the Regional planning workshop and assist the woredas in the preparation of their draft annual plans.	March 27-April 13	ZHDs
2	Compile and produce zonal core plan	April 13-20	ZHDs
D	Woreda Health Offices		
1	Conduct stakeholder consultation to map resources available for the next fiscal year	February 20-28	WorHOs in consultation with WOFED, Woreda Joint Steering Committees and health partners
2	Complete the woreda profile form for the core planning exercise at the regional planning workshop.	March 14-26	WorHOs and Technical Assistants
3	Participate in the regional planning workshop, revise the woreda annual health plan and submit to RHBs/ ZHDs	March 27-April 13	WorHOs, RHBs, ZHDs and TAs

	Annual planning activities	Time-frame	Involved Parties
4	They use the opportunity of the regional level workshop to finalize the detailed woreda plan that includes the core plan, other WorHO activities not in the core plan, and activities of the stakeholders at woreda level.	March 27-April 13	WorHOs, RHBs, ZHDs and TAs
5	Submit the detailed woreda annual plan to WoFED and woreda council for approval.	April 15	WorHOs
6	Finalize the woreda annual plan based on the approved woreda budget and communicate to the RHBs/ZHDs	June	WorHOs
E	Health Facilities (Hospitals and Health Centers)		
1	Prepare facility annual plan	April 5	Facility management in consultation with management boards

Annex 5 : Additional budget by service delivery mode and capital / recurrent costs

	Baseline	2010/11	2011/12	2012/13	2013/14	2014/15	Total	%
Base-case Scenario								
Family oriented community based services	181.76	527.17	568.60	567.44	615.00	655.68	2,933.89	33
Population oriented schedulable services	63.39	351.06	125.27	137.31	152.49	167.51	933.64	11
Individual oriented clinical services	418.97	603.74	619.33	742.08	868.34	993.74	3,827.25	43
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73	13
Total	883.06	1,677.01	1,507.07	1,662.54	1,883.51	2,096.38	8,826.50	100
Capital investment	628.74	581.01	382.68	347.83	337.83	327.41	1,976.76	22
Recurrent	254.32	1,095.99	1,124.39	1,314.71	1,545.68	1,768.96	6,849.74	78
Best-case Scenario								
Family oriented community based services	181.76	637.48	746.21	801.66	877.21	938.51	4,001.07	37
Population oriented schedulable services	63.39	383.36	190.23	172.96	188.46	203.71	1,138.72	11
Individual oriented clinical services	418.97	603.74	1,374.19	1,293.37	1,741.76	1,545.03	6,558.09	61
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73	10
Total	883.06	1,419.30	2,104.19	2,083.38	2,654.80	2,566.38	10,828.05	100
Capital investment	482.75	640.56	1,252.67	1,016.02	1,004.37	988.67	4,902.29	45
Recurrent	400.31	778.74	851.52	1,067.36	1,650.42	1,577.71	5,925.76	55

Annex 6: Estimated additional cost of HSDP-IV EFY 2003 - 2007 in million $US

Programmatic areas	Baseline spending 2009/10	Additional funding need under Base case Scenario	Additional funding need under Best case Scenario
1.1 Community Empowerment	6.79	87.05	112.47
1.2 M & E	7.36	84.02	106.10
1.3 Health System Strengthening	19.71	751.81	751.81
2.1 Maternal-Newborn and RH-Adolescent Health	31.27	317.13	424.35
2,2 Child Health	25.06	149.69	231.41
2.3 Nutrition	6.38	93.96	109.91
2.4. Hygiene and Environmental Health Services	7.87	124.52	130.42

Programmatic areas	Baseline spending 2009/10	Additional funding need under Base case Scenario	Best case Scenario
2.5 Prevention & Control of Malaria	111.45	238.23	405.41
2.6 Prevention & Control of HIV-AIDS	276.26	- 227.13	643.05
2.7 Prevention & Control of TB & Leprosy	152.72	45.52	671.67
2.8 Prevention & Control of Other Communicable Diseases	0.24	107.07	107.97
2.9 Prevention & Control of Non-Communicable Diseases	0.27	163.56	164.58
2.10 Public Health Emergency Management	0.45	35.86	38.11
2.11 Public Health/Nutrition Research & Quality Assurance/FSU	14.16	69.64	90.88
3.1 Expansion of PHC Facilities	23.48	328.31	328.31
3.2 Hospital Infrastructure	30.11	989.92	989.92
3.3 HR Salaries & Training	54.33	503.97	558.30
3.4 Pharmaceutical & Medical Equipment	97.00	434.97	434.97
3.5. Health Care Financing	2.17	38.91	38.91
TOTAL	867.06	4,337.00	6,338.55

Annex 7: Total Cost of HSDP IV in three Scenarios by Capital/Recurrent

	Baseline	2010/11	2011/12	2012/13	2013/14	2014/15	Total
		Base-case Scenario					
Family oriented community based services	181.76	527.17	568.60	567.44	615.00	655.68	2,933.89
Capital investment	73.52	65.63	32.88	12.73	7.80	3.79	122.83
Recurrent	181.76	461.55	535.72	554.71	607.20	651.88	2,811.06
Population oriented schedulable services	63.39	351.06	125.27	137.31	152.49	167.51	933.64
Capital investment	25.64	129.45	26.30	30.24	30.47	30.61	247.07
Recurrent	63.39	221.61	98.97	107.08	122.02	136.90	686.57
Individual oriented clinical services	418.97	603.74	619.33	742.08	868.34	993.74	3,827.25
Capital investment							

	298.31	265.69	231.38	224.95	222.81	220.02	1,164.86
Recurrent	120.66	338.05	387.95	517.13	645.53	773.73	2,662.39
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73
Capital investment	85.29	120.24	92.12	79.91	76.74	73.00	442.01
Recurrent	34.50	74.79	101.75	135.79	170.93	206.45	689.72
Total	883.06	1,677.01	1,507.07	1,662.54	1,883.51	2,096.38	8,826.50
Capital investment	628.74	581.01	382.68	347.83	337.83	327.41	1,976.76
Recurrent	254.32	1,095.99	1,124.39	1,314.71	1,545.68	1,768.96	6,849.74
		Best-case Scenario					
Family oriented community based services	181.76	637.48	746.21	801.66	877.21	938.51	4,001.07
Capital investment	73.52	86.59	76.75	87.70	80.81	71.28	403.13
Recurrent	181.76	550.89	669.45	713.96	796.40	867.24	3,597.94
Population oriented schedulable services	63.39	383.36	190.23	172.96	188.46	203.71	1,138.72
Capital investment	25.64	168.04	97.56	72.17	72.73	73.10	483.60
Recurrent	63.39	215.32	92.68	100.79	115.73	130.61	655.12
Individual oriented clinical services	418.97	603.74	1,374.19	1,293.37	1,741.76	1,545.03	6,558.09
Capital investment	298.31	265.69	986.24	776.24	774.09	771.30	3,573.56
Recurrent	120.66	338.05	387.95	517.13	967.67	773.73	2,984.53
District, provincial, national governance & management	119.78	195.03	193.87	215.70	247.68	279.45	1,131.73
Capital investment	85.29	120.24	92.12	79.91	76.74	73.00	442.01
Recurrent	34.50	74.79	101.75	135.79	170.93	206.45	689.72
Total	883.06	1,419.30	2,104.19	2,083.38	2,654.80	2,566.38	10,828.05
Capital investment	482.75	640.56	1,252.67	1,016.02	1,004.37	988.67	4,902.29
Recurrent	400.31	778.74	851.52	1,067.36	1,650.42	1,577.71	5,925.76

Annex 8: Financing Gap by Program for EFY 2003 to 2007

	Base case scenario	Best case scenario
1.1 Community Empowerment	87.05	112.47
1.2 Monitoring & Evaluation and Operational Research	84.02	106.10
1.3 System Strengthening & Capacity Development	751.81	751.81
2.1 Maternal-Newborn and RH-Adolescent Health	317.13	424.35
2.2 Child Health	149.69	231.41
2.3 Nutrition	93.96	109.91
2.4 Hygiene & Environmental Health	124.52	130.42
2.5 Prevention & Control of Malaria	238.23	405.41
2.6 Prevention & Control of HIV-AIDS	- 227.13	643.05
2.7 Prevention & Control of TB & Leprosy	45.52	671.67
2.8 Prevention & Control of Other Communicable Diseases	107.07	107.97
2.9 Prevention & Control of Non-Communicable Diseases	163.56	164.58
2.10 Public Health Emergency Management	35.86	38.11
2.11Public Health/Nutrition Research & Quality Assurance	69.64	90.88
3.1 Expansion of PHC Facilities	328.31	328.31
3.2 Hospital Infrastructure	989.92	989.92
3.3 HR Salaries & Training	503.97	558.30
3.4 Pharmaceutical & Medical Equipment	434.97	434.97
3.5. Health Care Financing	38.91	38.91

Annex 9: High Impact Interventions & Indicators

High Impact Interventions & Indicators		2010/11-2014/15		
1. Family oriented community based services	Indicators	Baseline	Base case Scenario	Best case Scenario
ITN for under five children	Proportion of children<5 who slept under ITN the previous night	42%	65%	86%
ITN for under five pregnant mother	Proportion of pregnant women who slept under ITN the previous night	42%	65%	86%
Quality of drinking water	Proportion of households treating water at home	8%	43%	88%
Hygeine & Sanitation	Proportion of HHs utilizing latrine	31%	60%	93%
Hand washing by mothers at critical time	Percent of mothers practicing hand washing with soap at critical time	13%	43%	88%
Indoor Residual Spraying (IRS)	proportion of Households covered with IRS (in IRS tatrgeted areas)	78%	82%	88%
Clean delivery and essential new born care	Proportion of births attended by HEWs	11%	38%	25%
Early breastfeeding and temperature management	Proportion of children put to breast in an hour of birth	69%	75%	92%
Exclusive breastfeeding for children 0-6 months	Proportion of children exclusively breastfeed for 6 months	49%	57%	70%
Continued breastfeeding for children 6-11 months	Proportion of children aged 12-15 months receiving breast milk.	75%	75%	85%
Complementary feeding	Proportion of children 6-9 months receiving complementary food and continued breastfeeding	54%	62%	84%
Oral Rehydration Therapy	Proportion of diarrhea cases continued feeding and drank more fluid	37%	65%	89%
Zinc for diarrhea management	% children with diarrhea who are treated with Zinc at community level	0%	62%	75%
Artemisinin-based Combination Therapy for children	% children treated for malaria at community level	3%	21%	29%
Artemisinin-based Combination Therapy for pregnant women	% of pregnant women treated for malaria at community level	5%	16%	22%
Artemisinin-based Combination Therapy for adults	Proportion of adults with malaria receiving ACT	4%	12%	19%
Malaria treatment with Chloroquine	% Fever Cases in children receiving Chloroquine treatment	3%	21%	32%
Community-based Pneumonia treatment for children	% children treated for pneumonia at community level	0%	17%	41%
Therapautic feeding for malnourished children/OTP	% of children with SAM receiving therapeutic feeding	5%	14%	19%
Iodized salt	Proportion of HHs using iodized salt	4%	45%	95%
Family Planning	Contraceptive Prevalence Rate	32%	66%	86%
Antenatal care	Proportion of pregnant women who received ANC 4+	31%	76%	88%
TT immunization	% of mothers with birth in last 12 months protected against tetanus	52%	57%	86%

High Impact Interventions & Indicators		2010/11-2014/15		
1. Family oriented community based services	Indicators	Baseline	Base case Scenario	Best case Scenario
TT immunization/Neonatal tetanus protection	Percentage of newborns protected against tetanus	42%	76%	88%
Detection and management of bacteriuria in pregnancy	% pregnant women with bacteruria screened and treated with antibiotics	12%	76%	86%
Detection and management of syphilis in pregnancy	% pregnant women with syphilis screened and treated with antibiotics	9%	76%	86%
Prevention and treatment of iron deficiency anemia in pregnancy	% pregnant women who receive Iron supplementation	10%	76%	88%
PMTCT	Proportion of HIV+ pregnant women receiving complete ARV course	8%	76%	80%
Condom Use	% of high risk sexual contacts with use of condom	17%	76%	80%
Antibiotics for opportunistic infection	% eligible HIV+ patient receiving cotrimoxazole prophylaxis	17%	77%	80%
Measles immunization	Proportion of children 12-23 months who received Measles vaccination	77%	84%	90%
Pentavalent immunization	Proportion of children 12-23 months vaccinated for Penta 3	82%	88%	96%
Fully Immunization	Proportion of children 12-23 months fully immunized	66%	82%	90%
Rota immunization	Proportion of children 12-23 months vaccinated for Rota	0%	0%	90%
Pneumococal immunization	Proportion of children 12-23 months vaccinated for Pneumococal	0%	0%	90%
Vitamin-A	Percentage of children aged 6-59 months who received at least two doses of vitamin-A in the last 12 months	94%	94%	96%
Deworming	Percentage of children aged 2-5 years of age who dewormed at least two times in the last 12 months	86%	90%	96%
Postnatal care	Proportion of mothers & newbors who received 2 follow up visits within one week of delivery	5%	25%	65%
Skilled delivery care	Proportion of birhs attended by skilled attendant	18%	65%	85%
Active third stage management of Labour	% of deliveries with active management of third stage	18%	65%	85%
B-EmONC	Proportion of women with major direct obstetric complications who are treated in B-EmONC facilities	18%	75%	96%
C-EmONC	% of deliveries by C/S (as a proportion of all births,norm 5%-15%)	20%	70%	96%
Neonatal resuscitation	Proportion of asphyixated newborn who received neonatal resuscitation	7%	75%	96%
Management of PROM	% Preterm prolonged rupture of membranes treated with antibiotics	10%	75%	96%
Pre -eclampsia management	% (pre) ecclampsia cases receiving Mag Sulf	3%	25%	65%
Neonatal infection management	% of neonatal sepsis cases treated with antibiotic	25%	42%	74%
U-5 pneumonia treatment	Proportion of with pneumonia treated with antibiotics	25%	25%	40%

High Impact Interventions & Indicators		2010/11-2014/15		
1. Family oriented community based services	Indicators	Baseline	Base case Scenario	Best case Scenario
Antibiotics for diarrhea and enteric fevers	Proportion of cases of dysentery and enteric fevers treated with antibiotics	6%	43%	88%
Measles Vitamine A management	Proportion of children with measles treated with Vit A	12%	48%	89%
Zinc for diarrhea management	Proportion of diarrhea cases treated with Zinc	0%	62%	88%
Chloroquine for malaria (P.vivax)	Proportion of fever cases in children receiving Chloroquine	7%	52%	88%
Artemisinin-based Combination Therapy for children	Proportion of children with malaria receiving ACT	8%	54%	89%
Artemisinin-based Combination Therapy for pregnant women	Proportion of pregnant women with malaria receiving ACT	15%	49%	88%
Artemisinin-based Combination Therapy for adults	Proportion of adults with malaria receiving ACT	15%	48%	88%
Management of complicated malaria	Proportion of complicated malaria requiring 2nd line drugs & managed	31%	69%	92%
Management of complicated malaria	Proportion of complicated & sever malaria being diagnosed & treated	30%	70%	92%
Therapautic feeding for malnourished children	Proportion of under 5 children managed for severe acute malnutrition	18%	45%	72%
STI management	% of adults with STI being diagnosed and treated	36%	50%	88%
Antibiotics for opportunistic infections	% AIDS cases treated for opportunistic infections	35%	50%	88%
Male circumcision	% circumcised men	92%	92%	92%
ART for children with Aids	Proportion of eligible children who are started on ART	52%	67%	83%
ART for pregnant women with AIDS	Proportion of eligible pregnant women started on ART	17%	60%	93%
ART adults with AIDS	% eligible HIV+ adults receiving ART	21%	40%	79%
Management of first line ART failures	% first line ART failures receiving adequate second line ART regimen	10%	31%	68%
Management of first line ART failures	Management 2nd line ART failure	5%	15%	42%
DOTS	TB Case Detection Rate	34%	45%	75%
DOTS	TB Treatment Succee Rate	84%	88%	90%
DOTS	TB Cure Rate	67%	70%	81%
Re-treatment TB cases	% TB cases re-treated among all TB patients	12%	70%	82%
Management of multidrug resistant TB (MDR)	% MDR TB patients treated with second line drugs of all estimated MDR cases	2%	16%	55%

Annex 10: Detailed Indicators for Monitoring HSDP IV QUALITY INDICATION

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
SO C1: Improve Access												
C1.1 Improve maternal, neonatal, child and adolescent health												
1	Maternal Mortality Ratio	Impact	590*					267	EDHS	Every 5 years	Population	
2	Institutional Maternal Mortality rate	Impact						Less than 1	HMIS	Quarterly	All HF	
3	Under-5 Mortality Rate	Impact	101/1000					68	EDHS	Every 5 years	Population	
4	Infant Mortality Rate	Impact	77/1000					31	EDHS	Every 5 years	Population	
5	Neonatal Mortality Rate	Impact	39/1000					15	EDHS	Every 5 years	Population	
6	Neonatal Mortality Rate (Institutional)	Impact						Less than 1	HMIS	Quarterly	All HF	
7	Total Fertility Rate	Impact	5.4					4	EDHS	Every 5 years	Population	
8	Teenage/adolescent Pregnancy Rate	Impact	17%					5%	EDHS	Every 5 years	Population	
9	Contraceptive Prevalence Rate	Outcome	32%					66%	EDHS / HMIS	Every 5 Years/ Yearly	Population/ All HF	
10	Contraceptive Acceptance Rate	Outcome	56%	66%	74%	79%	81%	82%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
11	Unmet need for Family Planning	Outcome	34%	24%	17%	12%	11%	10%	EDHS	Every 5 years	population	
12	Focused Antenatal Care Coverage (1+)	Outcome	68%	76%	83%	88%	89%	90%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
13	Focused Antenatal Care Coverage (4+)	Outcome	31%	53%	70%	81%	83%	86%	EDHS/HFS	Every 5 Years/ 2-3 years	Population/ HF	
14	Proportion of deliveries attended by a skilled health attendant	Outcome	18.4%	36%	49%	58%	60%	62%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
15	Proportion of deliveries attended by an HEW	Outcome	11%	22%	30%	35%	37%	38%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
16	Proportion of women with major direct obstetric complications who are treated in B-EmONC facilities	Outcome	12%	37%	56%	69%	72%	75%	HF Survey	2-3 years	HF	
17	Postnatal Care Coverage	Outcome	34%	52%	65%	74%	76%	78%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
18	Proportion of newborns who received 2 home visits in the first one week of birth	Outcome	5%	29%	47%	59%	62%	65%				
19	Caesarean Section Rate (of total pregnancy)	outcome	1%	4%	5%	6%	7%	7%	HMIS	Quarterly	Hospitals	
20	Abortion Care	Outcome							HMIS	Quarterly	All HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
21	Proportion of pregnant women who receive ANC at PMTCT site who receive testing for HIV	Outcome	16%	42%	63%	76%	79%	83%	HMIS	Quarterly	All HF	
22	Percent deliveries of HIV+ women that receive full course of ARV prophylaxis	Outcome	8%	36%	56%	70%	73%	77%	HMIS	Quarterly	All HF	
23	Number of HIV exposed infants for whom DNA PCR done	Outcome						100%		Quarterly		
24	Penta 3 coverage, (Rota Virus & Pneumococcal baseline is Zero)	Outcome	82%	88%	92%	95%	96%	96%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
25	Measles immunization	Outcome	77%	82%	86%	89%	89%	90%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
26	Fully Immunization	Outcome	66%	75%	83%	88%	89%	90%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
27	Protection at birth (PAB) against neonatal tetanus	Outcome	42%	60%	73%	82%	84%	86%	EDHS / HMIS	Every 5 Years/ Quarterly	Population/ All HF	
28	Proportion of newborn with neonatal sepsis who received treatment	Outcome	22%	43%	58%	69%	71%	74%	HFS	2-3 years	All HF	
29	Proportion of asphyxiated newborns who are resuscitated	Outcome	7%	34%	54%	68%	71%	75%	HFS	2-3 years	All HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
30	Proportion of under five children with pneumonia who received antibiotics at facility level	Outcome	25%	31%	31%	34%	37%	40%	HFS	2-3 years	All HF	
31	Proportion of under five children with pneumonia who received antibiotics at community level by HEWs	Outcome	0%	16%	29%	37%	39%	41%	HFS	2-3 years	All HF	
32	Proportion of children who seek treatment in the first 24 hrs of onset of fever among children who reported fever in the last two weeks	Outcome	15%	52%	68%	78%	82%	85%	HFS	2-3 years	All HF	
33	Proportion of under five children with diarrhea who received ORT	Outcome	37%	58%	73%	83%	86%	89%	HFS	2-3 years	All HF	
34	Proportion of U5 children diagnosed & treated for malaria	Outcome	32%	52%	67%	77%	80%	82%	HFS	2-3 years	All HF	
35	Percent of HCs & Hospitals providing PMTCT services	Output	24%	54%	77%	92%	96%	100%	HMIS	Annually	All HF	
36	Proportion of HCs with Available B-EmONC services	Output	5%	43%	72%	91%	95%	100%	HMIS	Annually	HC	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
37	Proportion of hospitals with available C-EmONC services	Output	51%	71%	85%	95%	98%	100%	HMIS	Annually	Hospitals	
38	Proportion of HF with safe abortion services	Output	4%	30%	45%	55%	65%	75%	HF Survey	Every 2- 3 years	Target HF	
39	Proportion of health centers that implement IMNCI	Output	52%	67%	84%	95%	97%	100%	HMIS	Annually	All HF	
40	Proportion of hospitals that implement IMNCI	Output	62%	100%	100%	100%	100%	100%	HMIS	Annually	All HF	
41	Proportion of facilities offering minimum basic package of adolescent friendly services	Output	10%	45%	65%	80%	90%	100%	HF Survey	2-3 years	All HF	
C 1.2 Improve nutritional status												
1	Prevalence of anemia in women of childbearing age(15-49)	Impact	27%					12%	EDHS	Every 5 years	population	
2	Underweight prevalence in U-5	Impact	38%					27%	EDHS	Every 5 years	population	
3	Stunting prevalence in U-5	Impact	46%					37%	EDHS	Every 5 years	population	
4	Wasting prevalence in U-5	Impact	11%					3%	EDHS	Every 5 years	population	
5	Proportion of low birth weight	Impact							HMIS	Quarterly	Health Facilities	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
6	Proportion of U-5 Children weighted for Growth monitoring	Outcome							HMIS	Quarterly	Health Facilities	
7	Proportion of under 5 children managed for severe acute malnutrition at HF	Outcome	23%	51%	71%	85%	88%	91%	HFS	Every 2 -3 years	Health Facilities	
8	Proportion of under 5 children managed for severe acute malnutrition by HEWs/OTP	Outcome	5%	11%	15%	18%	19%	19%	HFS	Every 2 -3 years	Health Facilities	
9	Cure, defaulter and mortality rate in TFP	Outcome		C=>75 ; D=<15 %; M=<5 %	C=>75; D=<15 %; M=<5 %	C=>75; D=<15 %; M=<5 %	C=>75; D=<15 %; M=<5 %	C=>75; D=<15%; M=<5%	HFS	Every 2 -3 years	Health Facilities	
10	Proportion of newborns breastfed within one hour of birth	Outcome	69%	78%	85%	90%	91%	92%	EDHS	Every 5 years	population	
11	Proportion of exclusive breast feeding 0-6 months	Outcome	49%					70%	EDHS	Every 5 years	population	
12	Proportion of children 6-9 months receiving complementary food and continued breastfeeding	Outcome	54%					65%	EDHS	Every 5 years	population	
13	Percentage of children aged 6-59 months who received at least two doses of vitamin-A in	Outcome	94%	95%	95%	96%	96%	96%	Admin Report	Annually		

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	the last 12 months											
14	Proportion of households using iodized salt	Outcome	4%	40%	68%	86%	90%	95%	EDHS	Every 5 years	population	
15	Percentage of children aged 2-5 years de-wormed two times in the last 12 months	Outcome	86%	88%	90%	92%	94%	96%	Admin Report	Annually		
16	Proportion of pregnant women supplemented with iron during pregnancy	Outcome	10%	41%	63%	79%	82%	86%	EDHS, Survey	Every 2- 3 years		
C 1.3. Improve hygiene & environmental health												
1	Proportion of HHs utilizing latrine	Outcome	20%	45%	63%	76%	79%	82%	HMIS	Annually	WorHO	
2	Proportion of HHs with latrine	Output	60%	74%	85%	92%	93%	95%	HMIS	Annually	WorHO	
3	Increase Proportion of households using HH water treatment and safe storage practices	Outcome	7%	36%	56%	70%	74%	77%	Survey	2- 3 years	Population	
4	Proportion of villages (Kebelles) free of open defecation	Outcome	15%	40%	50%	60%	70%	80%	Survey	2- 3 years		
C 1.4. Prevention and Control of Major Communicable Diseases												
Reduce incidence & prevalence of HIV/AIDS												

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
1	HIV mortality	Impact							EDHS	Every 5 years	Population	
2	Incidence of HIV	Impact	0.28%	0.22%	0.18%	0.16%	0.14%	0.14%	EDHS	Every 5 years	Population	
3	Proportion of young people aged 15-24 who use condom consistently while having sex with non-regular partners	Outcome	59%	73%	80%	80%	80%	95%	EDHS	Every 5 years	Population	
4	Proportion of population aged 15-49 years with comprehensive knowledge of HIV/AIDS	Outcome	22.60%	51.40 %	65.8	80.20%	80.20%	80.20%	EDHS	Every 5 years	Population	
5	HCT (VCT + PIHCT testing)	Outcome	5.8 million	9.2 million	9.2 million	9.2 million	9.2 million	9.2 million	HMIS	Quarterly	HFs	
6	Number of STI cases treated	Outcome	39267	60000	60000	60000	60000	60000	HMIS	Quarterly	HFs	
7	Cumulative number of people living with HIV/AIDS ever enrolled in HIV care	Outcome	443,964						HMIS	Quarterly	HFs	
8	Cumulative number of people living with HIV/AIDS ever started on ART	Outcome	246,347	324,021	377,669	431,317	458,141	484,966	HMIS	Quarterly	HFs	
9	Proportion of eligible pregnant women who are receiving ART	Outcome		26%	35%	44%	53%	95%	HMIS	Quarterly	HFs	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
10	Proportion of eligible children who are receiving ART	Outcome		54%	57%	59%	61%	95%	HMIS	Quarterly	HFs	
11	Proportion of eligible adults who are receiving ART (excluding pregnant women)	Outcome	53%	31%	40%	50%	59%	95%	HMIS	Quarterly	HFs	
12	Proportion of needy orphan & vulnerable children (OVC) who received care & support	Outcome	30%	35%	40%	43%	45%	50%	Admin Report	Quarterly	WorHO	
13	Number of needy PLHIV who received care and support	Outcome	60000	70000	80000	85000	90000	10000	Admin Report	Quarterly	WorHO	
14	Percent of eligible HIV+ receiving cotrimoxazole prophylaxis	Outcome	70%/35%	0%	0%	0%	0%	0%	HF survey	every 2 years	HF`	
Reduce incidence & prevalence of TB and Leprosy												
1	Mortality due to all forms of TB	**Impact**	64/100,000				20/100,000		EDHS	Every 5 years	Population	
2	TB Case Detection Rate	Outcome	34%	50%	63%	71%	73%	75%	HMIS	Quarterly	HF	
3	TB treatment Success	Outcome	84%	86%	88%	89%	90%	90%	HMIS	Quarterly	HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	rate											
4	Tuberculosis Cure Rate	Outcome	67%	74%	80%	83%	84%	85%	HMIS	Quarterly	HF	
5	Proportion of MDR TB cases treated with second line drugs	Outcome	2%	7%	15%	26%	39%	55%	Admin Report	Annually	WorHO	
8	Proportion of Health Posts providing community DOTS service	Output	6%	15%	23%	32%	41%	50%	Admin Report	Annually	WorHO	
9	Proportion of PLHIVs screened for TB	Outcome	15%	41%	54%	64%	72%	80%	HF Survey	Every 2 years	HFs	
10	Proportion of registered TB patients screened for HIV	Outcome	38%	100%	100%	100%	100%	100%	HMIS	Quarterly	HF	
11	Proportion of registered TB patients who are HIV positive	Outcome	24%					10%	HMIS	Quarterly	HF	
12	Proportion of TB negative PLHIVs put on INH Prophylactic Therapy (IPT)	Outcome	2%	34%	50%	66%	83%	80%	HF Survey	Every 2 years	HFs	
13	New cases of leprosy	Outcome							HMIS	Quarterly	HF	
14	MB Leprosy treatment completion Rate	Outcome	91%	93%	95%	96%	97%	98%	HMIS	Quarterly	HF	
15	Grade II disability rate among new cases of Leprosy	Outcome	7%	4%	3%	2%	1%	1%	HMIS	Quarterly	HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
Reduce incidence & prevalence of Malaria												
1	Lab confirmed (RDT/Microscopy) malaria case fatality ratio among children less than 5 years old and adults	Impact						Less than 2%	Survey	3-5 years	Population	
2	lab confirmed (RDT/Microscopy) malaria incidence per year, among children less than 5 years old and adults	Impact						Less than 5 per 1000 population per year	HMIS	Quarterly	All HF	
3	Prevalence parasite infection in children less than 5 years old & adults							**Less than 1%**	Survey	3-5 years	Population	
4	Morbidity attributed to malaria	Impact							HMIS	Quarterly	All HF	
5	Proportion of malarious kebele's in targeted woredas for elimination that reported no malaria cases for 24 months	Outcome		40%	60%	75%	90%	100%	HF Survey	2-3 years	All HF	
6	Laboratory-confirmed malaria cases seen in health facilities	Outcome	370,000	246,000	184,000	122,000	91,000	60,000	HMIS	Quarterly	All HF	
7	Proportion of suspected malaria cases who are diagnosed using RDTs or Microscpy with in	Outcome		100%	100%	100%	100%	100%	Survey	Every 2 years	HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	24 hrs of fever onset											
8	Proportion of households in malarious areas posses at least one LLINs	Output	65.6%	75%	83%	88%	89%	90%	Survey/Admin Report	Every 2 years	population	
9	Proportion of pregnant women who slept under LLIN the previous night	Outcome	41.2%	60%	73%	82%	84%	86%	Survey	Every 2 years	population	
10	Proportion of children under 5 sleeping under LLIN the previous night	Outcome	42.5%	60%	73%	82%	84%	86%	Survey	3-5 years	population	
11	Proportion of households in IRS targeted areas that were sprayed in the last 12 months	Output	55%	64%	70%	74%	75%	77%	Admin Report	Annually	WorHO	
Reduce incidence & prevalence of other communicable diseases												
1	Prevalence Schistosomiasis in endemic areas	Impact	14%	11%	9.50%	8.5	7.5	7%	Survey	Every 5 years	Population	
2	Prevalence Leishmaniasis in endemic areas	Impact	9.7% in males and 4.5% in females	8.7% & 3.5%	8.2% & 3.0%	7.5% & 2.5%	7.2% & 2.2%	7% & 2%	Survey	Every 5 years	Population	
3	Prevalence of lymphatic filariasis	Impact	23.7% M and 18.5% F	20.6% & 15.5%	19% & 14%	17.5% & 12.5%	16.8% & 11.8%	16% & 11%	Survey	Every 5 years	Population	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
4	Prevalence of intestinal parasites *(helminthiasis)*	Impact	No baseline available					40%	Survey	Every 5 years	Population	
5	Prevalence Trachomatous trichiasis	Impact	3.10%	2.26%	1.84%	1.42%	1.20%	1%	Survey	Every 5 years	Population	
Reduce incidence & prevalence of major non-communicable diseases												
1	Proportion of adult mortality attributable to chronic diseases/Take WHO Recommended process indicators (Only to have national doc)	Impact	25% DALYs rural and 35% DALYs urban	23% & 33%	22% & 32%	21% & 31%	20.5% & 30.5%	20% & 30%	20% in rural; 30% in urban			
2	Prevalence of high blood pressure among adults	Impact	31% in urban and 10% in rural	30% & 9.5%	28.5% & 8.5%	27% & 7%	25% & 6%	25% & 5%	Special Survey	Every 5 years	Population	
3	Proportion of health facilities providing integrated mental health services	Output	10%	26%	34%	42%	46%	50%	Administrative report/Supervision report	Every 5 years	HF	
4	Increase Cataract surgical cases (CSR)	Output	460	676	784	892	946	1000	HMIS	Annually	Hospitals	
SO C 2: Improve community ownership												
1	Proportion of model households graduated HEP	Output	25.6%	50%	67%	79%	82%	85%	Administrative report	Annually		
2	Proportion of community health promoters in relation to	Input	42%	60%	74%	83%	86%	88%	Administrative report	Annually		

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	need											
3	Proportion of health facilities with boards where communities are represented	Output	20%	22.20 %	50%	100%	100%	100%	Administrative report	Annually		
SO F 1: Improve resource mobilization and utilization												
1	Proportion of public health facilities retaining and using their revenue	Inputs	20%	22.20 %	50%	50%	100%	100%	Administrative report	Annually		
2	Share of internal revenue generated to total health budget	Inputs	9%	10 %	11%	12%	12.5%	13%	HMIS	Annually		
3	Proportion of reimbursed amount out of total patient fees waived	Inputs	70%	75%	80%	85%	90%	100%	HMIS	Quarterly		
4	Proportion of Public hospitals that implement private wing	Output	2%	74%	85%	93%	100%	100%	Administrative report	Annually		
5	Share of health budget as a proportion of total budget	Inputs	5.60%	9.40%	11.20%	13%	14%	15%	HMIS	Annually		
6	Per capita public expenditure on health	Inputs	16.1 USD	20	26	28	30	32 USD	HMIS	Annually		
7	Drug per capita expenditure	Inputs	0.49	0.83	1.20	1.57	1.94	2 USD	Administrative report	Annually		

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
8	Proportion of drug budget out of the total recurrent budget	Inputs	9%	10%	11%	12%	13%	14%	HMIS	Annually		
9	Proportion of public health facilities that have revised user fee to improve cost sharing	Inputs	1%	50%	100%	100%	100%	100%	Administrative report	Annually		
10	Proportion of out of pocket Health Expenditure from total health spending	Outcome	37%	35%	32.60%	27%	22.20%	18%	NHA Survey	Every 5 years		
11	Proportion of people enrolled in Health Insurance (disaggregate to formal and informal sector)	Inputs	1%	4%	11.50%	25%	40%	50%	Survey			
12	Ratio of health budget utilization to allocation	Output	70%	78%	82%	85%	88%	90	HMIS	Annually		
13	Increase financial liquidation rate	Output	63%	78%	80%	85%	90%	90%	Administrative report	Annually		
14	Increase proportion of funds dispersed as per performance	Output	0	32%	48%	72%	75%	80%	Administrative report	Annually		
SO P1: Improve Quality Health Services												
1	Inpatient mortality rate	Impact							HMIS	Quarterly	All HF	
2	Increase admission rate	Output	4.8 per 1,000						HMIS	Quarterly	All HF	
3	Bed Occupancy Rate	Output	50.80%	74%	78%	82%	84%	85%	HMIS	Quarterly	All HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
4	Average Length of Stay	Output	8.4 days	7.1	6.4	5.7	5.3	5 days	HMIS	Quarterly	All HF	
5	Outpatient Attendance per capita (Male & Female)	Output	0.2	0.4	0.5	0.6	0.65	0.7	HMIS	Quarterly	HF	
6	Customer satisfaction index	outcome	50%	70%	80%	90%	95%	100%	Survey	annually	HF	
7	Proportion of referred patients completing referral process successfully (from the beginning to the feedback)	Output	0					80%	Survey	annually	HF	
8	Proportion of hospitals with designated emergency unit	Input	50%	70%	80%	90%	95%	100%	administrative report	Annually	HF	
9	Proportion of emergency patient getting emergency care in less than 5 minutes	Output	50%	70%	80%	90%	95%	100%	survey	annually	HF	
11	Proportion of patients getting safe and adequate blood transfusion service	Output	50%	64%	71%	78%	82%	85%				
12	Proportion of standardized laboratories for integrated diseases at different levels	Inputs	25%	40%	50%	60%	65%	70%	survey	annually	HF	
SO P2: Improve Public Health Emergency preparedness and Response												

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
1	Proportion of epidemics averted (AWD, malaria and meningitis)	outcome						75%	administrative report	Annually		
2	Proportion of epidemics controlled with zero mortality	outcome						50%	administrative report	Annually		
SO P3: Improve Pharmaceutical Supply & Services												
1	Essential drugs availability	Inputs	65%	80%	90%	95%	98%	100%	HMIS	Quarterly	All HF	
2	Proportion of health facilities with stockout for essential drugs	Inputs	35%	20%	10%	5%	2%	0%	HMIS	Quarterly	All HF	
3	Procurement lead time (average time between order and delivery for supplier)	Inputs	240days/2	190	170	150	135	120 days	administrative report	Annually	PFSA	
4	Percentage of despensed drugs adequately labeled	Inputs	43%	60%	70%	78%	85%	90%	Survey	2-3 years	All HF	
5	Percentage of perescriptions containing antibiotics	Inputs	58%	45%	39%	34%	29%	25%	Survey	2-3 years	All HF	
6	Proportion of patients with adequate information on dispensed drugs	Output	68.00%					100%	Survey	2-3 years	All HF	
7	Percentage of stock wasted due to expiry	Output	8.24%	5%	4.50%	3.50%	2.50%	2%	administrative report	Annually	PFSA	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
SO P4: Improve Regulatory system												
1	Proportion of institutions complying with service standards	Output							Administrative report	Annually		
2	Proportion of licensed/certified health related institutions	Output	??	100%	100%	100%	100%	100%	administrative report	Annually		
3	Proportion of licensed/certified health stitutions	Output	??	100%	100%	100%	100%	100%	administrative report	Annually		
4	Proportion of licensed/certified food establishment	Output	??						administrative report	Annually		
5	Inspection coverage of Health Institutions	Output	??	100%	100%	100%	100%	100%	administrative report	Annually		
6	Inspection coverage of Health related Institutions	Output	??	10%	3%	5%	70%	90%	administrative report	Annually		
7	Inspection Coverage of food establishments	Output	??	10%	30%	60%	80%	90%	administrative report	Annually		
8	Proportion of registered and licensed traditional medicine	Output	??	10%	20%	40%	60%	80%	Survey	2-3 years		
9	Proportion of licensed professionals (Modern, aleternative and Traditional)	Output	??	100%	100%	100%	100%	100%	Survey	2-3 years		

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
10	Proportion of registered medicine and food	Output	??						Survey	2-3 years		
11	Coverage of medico-legal service	Output	??						administrative report	Annually		
12	Quarentine coverage	Output	??	100%	100%	100%	100%	100%	administrative report	Annually		
13	Abuse pervalence rate	Outcome							Survey	2-3 years		
14	Proportion of regulatory measures taken on unethical and negligent professionals	Output	??						administrative report	Annually		
SO P5: Improve evidenced-based decision-making through enhanced harmonization and alignment												
1	Proportion of health facilities and health programme managers using HMIS data for decision making	Inputs		100%	100%	100%	100%	100%	Survey	2-3 years	all level	
2	Report completeness (Percentage of routine/population based reports that were received)	inputs	6%	40%	57%	74%	82%	90%	HMIS	Quarterly	HF	
3	Report Timeliness (Percentage of routine/population based reports that were received within the time specified)	Inputs	57%	70%	77%	83%	86%	90%	HMIS	Quarterly	HF	
4	Correspondence between data reported	Output	15%	45%	60%	75%	82%	90%	HMIS	Quarterly	HF	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	and recorded (LQAS)											
5	Proportion of woredas with evidence-based plan aligned vertically & horizontally	Inputs	100%	100%	100%	100%	100%	100%	Admin Report	Annually	all level	
6	Proportion of partners implementing one plan	Inputs		100%	100%	100%	100%	100%	Survey	Annually	all level	
7	Proportion of partners using the national M&E framework (alignment and harmonization)	Inputs		100%	100%	100%	100%	100%	Survey	Annually	all level	
8	Proportion of health developmental partners providing fund through MDG Pool Fund	Inputs						75%	Admin Report	Annually	all level	
9	Proportion of researched conducted to address priority public health problems	Inputs						95%	Admin Report	Annually	all level	
SO CB 1 : Improve health infrastructure												
1	Health Post to population ratio	Output						1;5000	HMIS	Annually	WorHO	
2	Health Centre to population ratio	Output						1: 25000	HMIS	Annually	WorHO	
3	Primary Hospital to population ratio	Output						1;100,000	HMIS	Annually	WorHO	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
4	Number of constructed general hospitals	Inputs						1;1,000,000	Admin Report	Annually	RHB	
5	Number of constructed referral hospitals	Inputs						1;5,000,000	Admin Report	Annually	RHB	
6	Number of maintained Health Centers	Inputs						100%	Admin Report	Annually	RHB	
7	Number of maintained Hospitals	Inputs						100%	Admin Report	Annually	RHB	
8	Number of equiped & furnished Health Posts	Inputs						100%	Admin Report	Annually	RHB	
9	Number of equiped & furnished Health Centers	Inputs						100%	Admin Report	Annually	RHB	
10	Number of equiped & furnished Hospitals	Inputs						100%	Admin Report	Annually	RHB	
11	Number of Health facilities with communication equipment							100%				
12	Number of Health facilities with electricity							100%				
13	Number of Health facilities with water supply							100%				
14	Number of Health facilities with latrine with functioning water							100%				

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
	supply											
15	Number of new technologies (vaccines) adopted and used	Inputs						10	Admin Report	Annually	RHB	
16	Number of hospitals implementing EMR	Inputs						100%	Admin Report	Annually	RHB	
17	Number of Health Facilities implementing EHMIS	Inputs						100%	Admin Report	Annually	RHB	
18	Number of hospitals with tele-medicine											
SO CB2:Improve human capital and Leadership												
1	Leadership development index	Output							HMIS	Annually	WorHO	
2	Distribution of HRH by geographical location by category	Inputs							HMIS	Annually	WorHO	
3	Percentage of critical gap filled by TA (Technical Assistance)	Inputs							HMIS	Annually	WorHO	
4	Number of trained & deployed health professionals by category	Inputs							HMIS	Annually	WorHO	
5	Proportion of institutions staffed as per standard	Inputs							HMIS	Annually	WorHO	

Sr. No	Indicators	Type	Baseline	Yearly Target					Source	Periodicity	Level of data collection	Remark
				1	2	3	4	5				
6	Health Workforce Density: from 0.7 per 1,000 to 1.7 per 1,000	Output	0.7/1000					1.7/1000				
7	Physician to Population Ratio: from 1:37,996 to 1:5,500	Inputs	1:37,996					1:5,500				
8	Proportion of institutions staffed as per standard	Inputs						100%	HMIS	Annually		
9	Proportion of PHCU that use Workload based staffing standard	Inputs						100%				
10	Implementation of e-HRIS at regional level	Inputs						100%				
12	Competency level for essential knowledge and skill (disaggregated by category)	Output						100%				

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